DOCUMENT RESUME

ED 465 734 SP 040 886

AUTHOR	Bogden, James F.
TITLE	Fit, Healthy, and Ready To Learn: A School Health Policy Guide. Part I: Physical Activity, Health Eating, and Tobacco-Use Prevention.
INSTITUTION	National Association of State Boards of Education, Alexandria, VA.
SPONS AGENCY	Centers for Disease Control (DHHS), Atlanta, GA. Div. of Adolescent and School Health.
ISBN	ISBN-1-58434-042-8
PUB DATE	2000-03-00
NOTE	230p.
CONTRACT	U87-CCU310215-02
AVAILABLE FROM	National Association of State Boards of Education, 277 South Washington Street, Suite 100, Alexandria, VA 22314 ($22). Tel: 703-684-4000; Tel: 800-220-5183 (Toll Free); Fax: 703-836-2313; e-mail: boards@nasbe.org; Web site: http://www.nasbe.org/catalog.html.
PUB TYPE	Guides - Non-Classroom (055)
EDRS PRICE	EDRS Price MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	*Comprehensive School Health Education; Dietetics; *Eating Habits; Educational Policy; Elementary Secondary Education; *Health Promotion; Nutrition Instruction; Physical Activity Level; Physical Education; *School Health Services; *School Policy; *Smoking
IDENTIFIERS	Risk Reduction; Smoking Cessation

ABSTRACT

This policy guide reflects the concerns and priorities of education policymakers and administrators, addressing broad policy issues and focusing on physical activity, healthy eating, and tobacco use prevention. Section 1, "Overview," reviews the issue and presents sample policies. Section 2, "The Art of Policymaking," discusses what policy is, the policy development process, who's who in education policymaking, and enlisting public support. Section 3, "General School Health Policies," discusses a vision for school health, the coordinated school health program, administration and evaluation, health education, and a well-prepared staff. Section 4, "Policies To Encourage Physical Activity," includes purpose and goals, physical education, extracurricular physical activity programs, other opportunities for physical activity, and safety guidelines. Section 5, "Policies To Encourage Healthy Eating," offers purpose and goals, nutrition education, the Food Service Program, other food choices at school, and services for nutrition related health problems. Section 6, "Policies To Discourage Tobacco Use," includes purpose and goals, tobacco-free environments, tobacco-use prevention education, and assistance to overcome tobacco addiction. (Sections contain references.) (SM)

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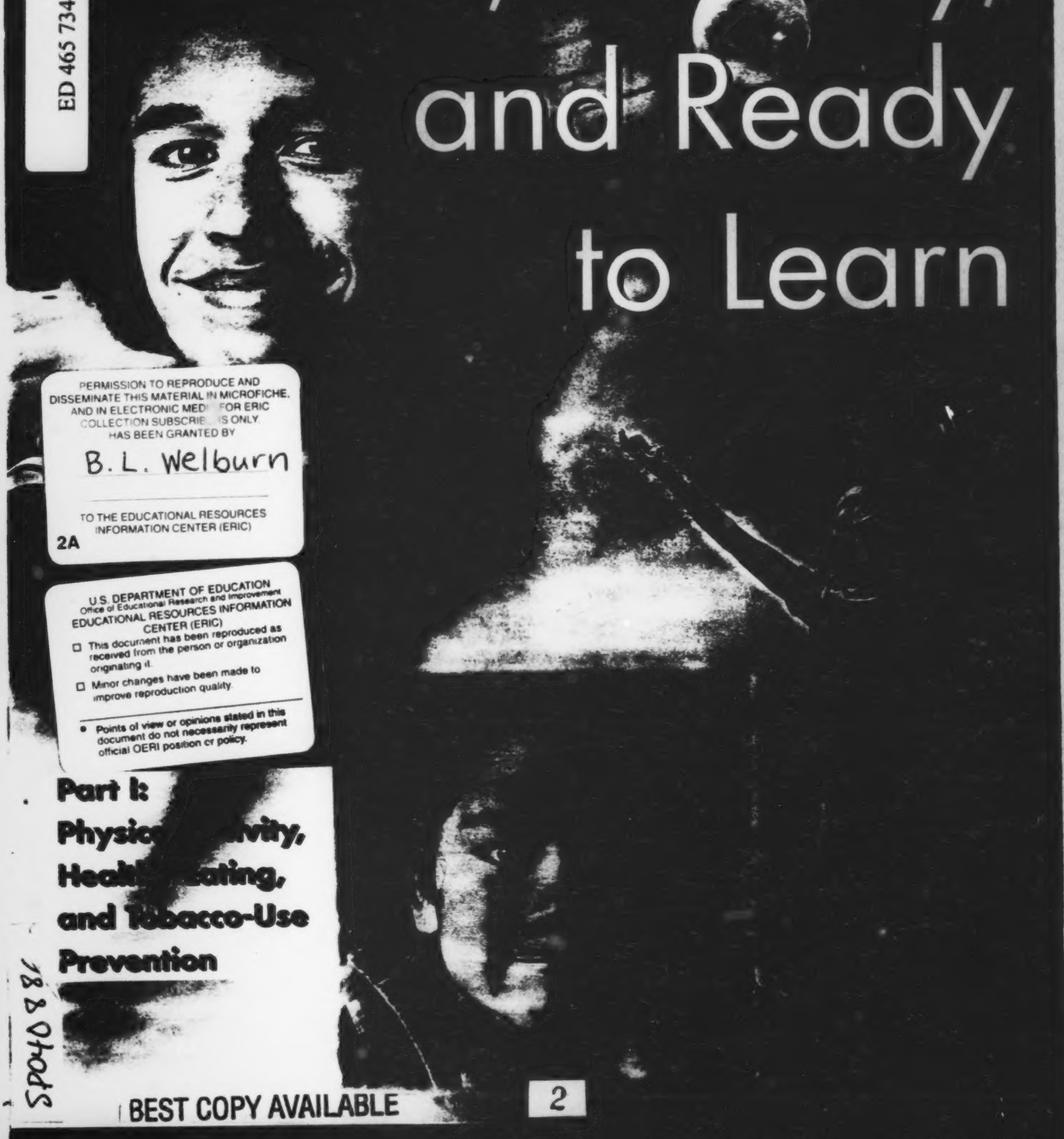

Part I:
Physic[illegible]ivity, Healt[illegible]ating, and Tobacco-Use Prevention

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A SCHOOL HEALTH POLICY GUIDE

Fit, Healthy, and Ready to Learn

A School Health Policy Guide

Part I: Physical Activity, Healthy Eating, and Tobacco-Use Prevention

James F. Bogden, MPH, Author
Carlos A. Vega-Matos, MPA, Project Director

March 2000

This publication was developed under a cooperative agreement with the Division of Adolescent and School Health of the U.S. Centers for Disease Control and Prevention; grant #U87/CCU310215-02. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

NASBE
NATIONAL ASSOCIATION OF STATE BOARDS OF EDUCATION
277 South Washington Street, Suite 100
Alexandria, VA 22314
(703) 684-4000
boards@nasbe.org
www.nasbe.org

Acknowledgements

NASBE extends its grateful appreciation to Brenda Z. Greene, Director of School Health Programs at the **National School Boards Association** (NSBA), and her staff for their extensive collaboration in the development of this document.

The following people reviewed drafts and provided valuable advice and assistance:

Dorothy Beardmore
President
Michigan State Board of Education

Margie Bradford
NSBA Board of Directors
Chair, NSBA HIV/AIDS & School Health
Programs Advisory Committee

Cathy David
Principal, Charles Barrett Elementary school
Alexandria, Virginia

Winton Goodrich
Associate Executive Director
Vermont School Boards Association

Richard Lyons
Superintendent
Hampden, Maine School District

Eva Marx
Associate Director, Center for School Health
Programs
Educational Development Center, Inc.

Kristine Muerer, Ph.D.
Director, School Health Unit
New Mexico State Department of Education

Philip R. Nader, M.D.
American Academy of Pediatrics
Chief, UC San Diego Division of Community
Pediatrics

JoAnne Owens-Nausler, Ph.D.
Director of Professional Development
American School Health Association

Betty Preston
President
Missouri State Board of Education

Emmalou Rodriguez
Former Member
New Mexico State Board of Education

Barry D. Sackin, SFNS
Director of Government Affairs and
Technology
American School Food Service Association

Marie Louise Sterne
Education Consultant
Fairfax, Virginia

Howard L. Taras, M.D.
American Academy of Pediatrics
Community Pediatrics, UC San Diego

Meg Wagner, M.S., R.D., L.D.
Health Education Consultant
Ohio Department of Education

At the Centers for Disease Control and
Prevention (CDC), Division of Adolescent
and School Health (DASH):

Howell Wechsler, Ed.D., MPH
Mary Vernon, M.D., MPH
Linda Crossett, R.D.H.
Charlene R. Burgeson, M.A.
Sarah Kuester, M.S., R.D.
... and many others

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ISBN 1-58434-042-8

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A. Overview

1. Introduction

About two-thirds of all deaths in the United States and large amounts of illness, suffering, and financial cost are due to heart disease (34 percent of all deaths), cancer (25 percent), and stroke (7 percent).[1] A small number of health-risk behaviors contribute enormously to these major causes of death and illness: tobacco use, poor dietary patterns, and physical inactivity.[1]

These personal behaviors have several things in common. They are often established during youth and extend into adulthood; they are interrelated; and they contribute simultaneously to poor health, poor education, and poor social outcomes.[1] These major health-risk factors also share another important feature: they are *preventable*.

> **Schools Have an Important Role**
>
> **As a result of its research and analysis, the study group firmly believes that schools have an important role to play in addressing the needs of students by helping them succeed academically and by supporting the growth that will enable them to lead successful, productive adult lives. The question is not *whether* schools should address non-academic barriers to learning but *what* they can do both alone and with others to support learning.**
>
> **—National Association of State Boards of Education[2]**

Schools have an important role in helping to prevent tobacco use, poor dietary patterns, and physical inactivity behaviors. Nearly all young people are enrolled in school, and schools are often the only place where they have access to reliable health information as well as constant interaction with well-prepared professionals who can provide consistent reinforcement of positive behaviors.

School health programs frequently have suffered from a perception that they are supplementary to a school's core functions and are not truly necessary— nice to have when enough money is available but among the first on the chopping block when budgets are tight. Yet the National Association of State Boards of Education (NASBE) and many state and local policymakers nationwide are convinced that good school health programs play a crucial supporting role to excellence in education. School health programs can help ensure that students are fit, healthy, and ready to learn every day and in every grade.

Why this policy guide was developed

The Division of Adolescent and School Health (DASH) of the Centers for Disease Control and Prevention (CDC) has produced several sets of guidelines that

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identify what schools can do to address physical inactivity, poor dietary patterns, and tobacco use, as listed in the box below. These guidelines provide state-of-the-art, scientifically reliable information on what constitutes effective school health programs.

When surveyed about what would be needed for CDC's guidelines to become widely implemented in the nation's schools, many school health practitioners responded that a solid foundation of policy is critically needed in states, districts, and schools. They stated that written policies provide the necessary assurance that high-level decision makers support school health goals.

The CDC then approached NASBE, publishers of the widely used policy guide *Someone at School has AIDS: A Complete Guide to School Policies Concerning HIV Infection* (1996), to request development of a similar publication that would address the three sets of guidelines. The CDC also asked the National School Boards Association (NSBA) to expand its existing school health policy database to include materials and examples of actual district policies that address these topics, and requested that both organizations provide technical assistance to state and local policymakers and administrators. NASBE and NSBA have worked together closely to develop this policy guide.

CDC Guidelines for School Health Programs

"Guidelines for school and community programs to promote lifelong physical activity among young people." *MMWR* 1997; 46 (No. RR-6).

"Guidelines for school health programs to promote lifelong healthy eating." *MMWR* 1996; 45 (No. RR-9).

"Guidelines for school health programs to prevent tobacco use and addiction." *MMWR* 1994; 43 (No. RR-2).

Single copies of each document are available from the CDC Division of Adolescent and School Health, 4770 Buford Highway, NE, Mail Stop K-32, Atlanta, GA 30341-3717; telephone: (770) 488-3168; FAX: (770) 488-3111; e-mail: ccdinfo@cdc.gov.

The documents can also be downloaded in their entirety at www.cdc.gov/ nccdphp/dash.

Intended audiences

Fit, Healthy, and Ready to Learn is designed to reflect the concerns and priorities of education policymakers and administrators. Additional audiences who might benefit from this information include those who want to contribute to the process of developing school health policies, such as school staff involved in health education or services, health professionals, academicians, family members, students, and other interested members of the community.

This guide primarily addresses broad policy issues; it does not detail how to best plan and manage the various components of a quality school health program, nor does it purport to summarize all the exhaustive research findings about school health programs. A wealth of specialized assistance on program design, administration, and the scientific knowledge base is available from professional associations, government agencies, foundations, and other sources, many of which are listed in the resource lists found throughout the guide.

How this guide is organized

The second section of this chapter includes all of the sample policy language presented in subsequent chapters. States, local school districts, public schools, and private schools can use or adapt these sample policies as needed.

The chapter entitled "The Art of Policymaking" (Tab B) provides an orientation to the policymaking process for those who want to advance school health goals.

"General School Health Policies" (Tab C) provides an overall policy framework for school health programs. Priority health topics and policies pertaining to specific aspects of school health programs can be integrated within this framework.

Later chapters suggest additional policies that add depth and detail to the three CDC guidelines documents: "Policies to Encourage Physical Activity" (Tab D), "Policies to Encourage Healthy Eating" (Tab E), and "Policies to Discourage Tobacco Use" (Tab F).

Each policy chapter is divided into sections that concentrate on major policy components. In addition to the sample policies, excerpts of actual state and local policies are highlighted as examples of different ways to approach the same policy objective. Sidebar boxes have notable quotations and valuable information that supporters can use to illustrate the need for school health policy initiatives.

Each section ends with a list of resources. The organizations included offer a broad range of assistance, have a national scope, are easily accessed, provide materials at low or no cost, and/or offer specialized expertise. The lists are by no means complete. Scores of other organizations provide high-quality assistance and advice to educators, policymakers, and parents; hundreds of informative books and articles are also available. The listed resources should be considered jumping-off points for additional research.

CDC continues to produce guidelines on various aspects of school health programs. New research and lessons from experience constantly emerge. *Fit, Healthy, and Ready to Learn* is designed to be flexible so that new and revised chapters can be incorporated in the future.

2. The Sample Policies

The recommended policies are written as statements of best practice that all states, school districts, public schools, and private schools should endeavor to adopt. They were crafted from borrowed ideas and phrases from the CDC guidelines, actual state and local policies collected by NASBE and NSBA, and comments reflecting the expert opinions of many reviewers. The policies can be adapted or revised to fit the needs of individual states, districts, and schools.

Collected below are all the sample policies that are presented and discussed in the chapters that follow.

General School Health Policies [Tab C]

1. A VISION FOR SCHOOL HEALTH

INTENT. Families are the primary teachers and caregivers for their children. The present and future health, safety, and well-being of students are also the concern of *state/district/school*. Schools have a duty to help prevent unnecessary injury, disease, and chronic health conditions that can lead to disability or early death. For students to learn to take responsibility for their own health and to adopt health-enhancing attitudes and behaviors:

- every school shall be a safe and healthy place for children and employees to learn and work, with a climate that nurtures learning, achievement, and growth of character;
- all students shall be taught the essential knowledge and skills they need to become "health literate"—that is, to make health-enhancing choices and avoid behaviors that can damage their health and well-being;
- each school shall be organized to reinforce students' adoption of health-enhancing behaviors, and school staff shall be encouraged to model healthy lifestyles; and
- school leaders shall ensure that the nutrition, health services, and social services children need in order to learn are provided either at the school site or in cooperation with other community agencies.

RATIONALE. Health and success in school are interrelated. Schools cannot achieve their primary mission of education if students and staff are not healthy and fit physically, mentally, and socially. Credible surveys indicate that alarming proportions of young people engage in behaviors that put them at risk of serious health problems. In addition, the nation's leading health authorities recommend that schools take an active role in preventing disabling chronic health conditions that create misery and consume a burdensome share of the nation's resources.

2. THE COORDINATED SCHOOL HEALTH PROGRAM

COORDINATED SCHOOL HEALTH PROGRAM. Every school district and school shall develop, adopt, and implement a comprehensive plan for a thorough, well-coordinated school health program that shall:

- be designed in response to demonstrated needs in the community;
- be based on models that demonstrate evidence of effectiveness;

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- emphasize a positive youth development approach;
- make efficient use of school and community resources; and
- respond to families' needs and preferences.

The coordinated school health program plan shall incorporate the following eight components within a single framework:

1. a **school environment** that is safe; that is physically, socially, and psychologically healthful; and that promotes health-enhancing behaviors;
2. a sequential **health education curriculum** taught daily in every grade, pre-kindergarten through twelfth, that is designed to motivate and help students maintain and improve their health, prevent disease, and avoid health-related risk behaviors and that is taught by well-prepared and well-supported teachers;
3. a sequential **physical education curriculum** taught daily in every grade, pre-kindergarten through twelfth, that involves moderate to vigorous physical activity; that teaches knowledge, motor skills, and positive attitudes; that promotes activities and sports that all students enjoy and can pursue throughout their lives; that is taught by well-prepared and well-supported staff; and that is coordinated with the comprehensive school health education curriculum;
4. a **nutrition services program** that includes a food service program that employs well-prepared staff who efficiently serve appealing choices of nutritious foods; a sequential program of nutrition instruction that is integrated within the comprehensive school health education curriculum and coordinated with the food service program; and a school environment that encourages students to make healthy food choices;
5. a school **health services program** that is designed to ensure access or referral to primary health care services; foster appropriate use of health care services; prevent and control communicable disease and other health problems; provide emergency care for illness or injury; and is provided by well-qualified and well-supported health professionals;
6. a **counseling, psychological, and social services program** that is designed to ensure access or referral to assessments, interventions, and other services for students' mental, emotional, and social health and whose services are provided by well-qualified and well-supported professionals;
7. integrated **family and community involvement activities** that are designed to engage families as active participants in their children's education; that support the ability of families to support children's school achievement; and that encourage collaboration with community resources and services to respond more effectively to the health-related needs of students; and
8. a **staff health promotion program** that provides opportunities for school staff to improve their health status through activities such as health assessments, health education, and health-related fitness activities.

EFFECTIVE DATE. All *districts/schools* shall present a plan for a coordinated school health program to *whom* by *date*. The program shall be operational by *date*.

3. ADMINISTRATION AND EVALUATION

RESPONSIBILITIES OF ADMINISTRATORS. The *superintendent/school principal/other* or his/her designee shall be responsible for:

- preparing a comprehensive plan for eight elements of a coordinated school health program, with input from students and their families;
- ensuring that the various components of the school health program are integrated

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within the basic operations of the *district/school*, are efficiently managed, reinforce one another, and present consistent messages for student learning;

- developing procedures to ensure compliance with school health policies;
- supervising implementation of school health policies and procedures;
- negotiating provisions for mutually beneficial collaborative arrangements with other agencies, organizations, and businesses in the community; and
- reporting on program implementation, results, and means for improvement to *whom and how regularly*.

RESPONSIBILITIES OF THE SCHOOL HEALTH COORDINATOR. Each *school/district* shall appoint a school health coordinator to assist in the implementation and coordination of school health policies and programs by:

- ensuring that the instruction and services provided through various components of the school health program are mutually reinforcing and present consistent messages;
- facilitating collaboration among school health program personnel and between them and other school staff;
- assisting the superintendent/school principal and other administrative staff with the integration, management, and supervision of the school health program;
- providing or arranging for necessary technical assistance;
- identifying necessary resources;
- facilitating collaboration between the district/school and other agencies and organizations in the community who have an interest in the health and well-being of children and their families; and
- conducting evaluation activities that assess the implementation and results of the school health program, as well as assisting with reporting evaluation results.

RESPONSIBILITIES OF THE SCHOOL HEALTH COUNCIL. A school health council shall be established that is composed of diverse members of the school community representing the eight components of the coordinated school health program, plus members of the community, family members, and students as appropriate. The council shall meet regularly to assess the progress of all aspects of the school health program and assist *district/school* leaders with general oversight, planning, evaluation, and periodic revisions of all aspects of the school health program.

To minimize inefficiency and duplication, the scope of duties, reporting procedures, and means of coordination shall be established in writing for this council and for all other planning committees and advisory councils.

RESPONSIBILITIES OF OTHER ADMINISTRATIVE STAFF. The food service program and its personnel shall be under the general supervision and authority of a food service director who reports to *determined by district or school*. State and district officials retain legal oversight responsibility to ensure compliance with state and federal laws, regulations, and guidelines.

Each middle school and high school shall appoint an athletic and/or student activities director to be primarily responsible for development, implementation, and ongoing administration of the school's intramural and interscholastic athletic programs.

The school health coordinator, food service director, athletic director, and student activities director shall be included as members of site-based management teams, district/school improvement councils, and other governance or advisory bodies as appropriate.

EVALUATION. Multiple indicators shall be used to assess the implementation and results of each component of the school health program. Health-related behaviors of students shall be anonymously surveyed every two years. The evaluation plan shall also

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include assessments of students' and families' satisfaction with the school health program.

POLICY REVIEW. The school board/other decision making body shall review school health policies to assess their effectiveness and make appropriate adjustments at least every three years.

4. HEALTH EDUCATION

INTENT. A comprehensive program of health education that is designed to promote healthful living and discourage health-risk behaviors shall be taught at every grade level, pre-kindergarten through twelfth grade. Health-literate graduates of the school system shall be able to:

- comprehend concepts related to health promotion and disease prevention;
- access valid health information and health-promoting products and services;
- practice health-enhancing behaviors and reduce health risks;
- analyze the influence of culture, media, technology, and other factors on health;
- use interpersonal communication skills to enhance health;
- use goal-setting, decision-making, and self-management skills to enhance health; and
- advocate for personal, family, and community health.

INSTRUCTIONAL PROGRAM DESIGN. The health education program shall be an integral part of a coordinated school health program, be consistent with the state's standards/guidelines/frameworks, and be reviewed by the school health council. The health education program shall:

1. utilize educational theories and methods that have credible evidence of effectiveness;
2. emphasize learning and practicing the skills students need for healthful living;
3. build functional knowledge and skills from year to year (i.e., be sequential in design);
4. include accurate and up-to-date information;
5. use active, participatory instructional strategies and techniques;
6. be appropriate to students' developmental levels, personal behaviors, and cultural backgrounds;
7. be consistent with community standards;
8. focus on the behaviors that have the greatest effect on a person's health and emphasize the short-term and long-term consequences of personal health behaviors;
9. encourage students to assess their personal behaviors and habits, set goals for improvement, and resist peer and wider social pressures to make unhealthy choices;
10. stress the appealing aspects of living a healthy lifestyle;
11. address students' health-related concerns;
12. utilize curriculum materials that are gender-neutral and nonstereotyping;
13. assess students' achievement of health knowledge and skills with assessment instruments aligned with the curriculum;
14. be appropriately adapted to the special needs of students with disabling conditions, students with limited English proficiency, and students in alternative education settings;
15. be taught by well-prepared instructors with adequate support;
16. be allocated enough instructional time to achieve the program's goals;

17. be taught in classes that are the same average size as classes in other subject areas;

18. include means for program evaluation; and

19. involve parents and families as active partners in their children's learning.

GRADING. All students shall be regularly assessed for attainment of the health education learning objectives. Course grades shall be awarded in the same manner as in other subject areas and be included in calculations of grade point average, class rank, and academic recognition programs such as honor roll.

Students' results on health-related portions of state and district academic achievement tests shall be considered the same as in other subject areas for determining school progress indicators and in application of consequences in accordance with the established provisions of the *state/district* accountability system.

CURRICULUM INTEGRATION. Health education topics shall be integrated into the instruction of other subject areas to the greatest extent possible. Such cross-teaching is intended to complement, not substitute for, a comprehensive health education program.

PARENTAL REVIEW. Parents and guardians shall have convenient opportunities to preview all curricula and materials. A student may be excused from receiving school instruction in specific topics upon the written request of a parent or legal guardian. The parent/guardian must ensure that the topics the student is excused from are learned at home or elsewhere, and the student will be assessed for attainment of the health education learning objectives in the same manner as students not excused.

COLLABORATION. To the extent practicable, school staff shall cooperate with other agencies, organizations, and individuals conducting health education in the community. Guest speakers invited to address students shall receive appropriate orientation to the relevant policies of the *school/district*. School staff are encouraged to work with community organizations to provide opportunities for student volunteer work related to health.

5. WELL-PREPARED STAFF

QUALIFICATIONS. All personnel involved in the school health program shall possess the necessary qualifications and training essential to their duties. Professional staff shall be currently licensed, certified, and/or recertified according the requirements established by *state board or other agency* for the positions in which they are employed and are expected to follow the performance and ethical standards established by their professional organizations.

Health and physical education teachers shall be required to periodically demonstrate their abilities to apply the content knowledge and instructional skills that are critical to the successful teaching of health and physical education.

PROFESSIONAL DEVELOPMENT. All personnel involved in the school health program shall participate in ongoing professional development activities that are directly related to their responsibilities. In particular, instructional staff who teach health topics shall satisfactorily complete professional development activities that provide basic knowledge about health and health education, including practice with teaching strategies designed to influence students' health-related behaviors and attitudes.

Professional development programs shall:

- respond to the professional improvement needs of staff and schools;
- be designed to transfer knowledge and skills based on theories and methods proven effective by published research;
- encourage reflection and professional discourse among peers about classroom practice;

- be made available to staff at their place of work to the greatest feasible extent;
- involve staff unions and professional associations in planning and implementation;
- provide necessary information about school health-related standards, guidelines, frameworks, regulations, policies, and recommendations of *state/district/school* and federal agencies; and
- provide relevant information about other disciplines to foster efficient collaboration among professionals.

Policies to Encourage Physical Activity [Tab D]

1. PURPOSE AND GOALS

INTENT. Every student shall be physically educated—that is, shall develop the knowledge and skills necessary to perform a variety of physical activities, maintain physical fitness, regularly participate in physical activity, understand the short- and long-term benefits of physical activity, and value and enjoy physical activity as an ongoing part of a healthful lifestyle. In addition, staff are encouraged to participate in and model physical activity as a valuable part of daily life.

School leaders shall develop and implement a comprehensive plan to encourage physical activity that includes the following:

- a sequential program of physical education that involves moderate to vigorous physical activity on a daily basis; teaches knowledge, motor skills, self-management skills, and positive attitudes; promotes activities and sports that students enjoy and can pursue throughout their lives; is taught by well-prepared and well-supported staff; and is coordinated with the health education curriculum;
- time in the elementary school day for supervised recess;
- opportunities and encouragement for students to voluntarily participate in before- and after-school physical activity programs, such as intramurals, clubs, and, at the high school level, interscholastic athletics;
- joint school and community recreation activities;
- opportunities and encouragement for staff to be physically active; and
- strategies to involve family members in program development and implementation.

The program shall make effective use of school and community resources and equitably serve the needs and interests of all students and staff, taking into consideration differences of gender, cultural norms, physical and cognitive abilities, and fitness levels.

RATIONALE. Schools have a responsibility to help students and staff establish and maintain lifelong habits of being physically active. According to the U.S. Surgeon General, regular physical activity is one of the most important things people can do to maintain and improve their physical health, mental health, and overall well-being. Regular physical activity reduces the risk of premature death in general and of heart disease, high blood pressure, colon cancer, and diabetes in particular. Promoting a physically active lifestyle among young people is important because:

- through its effects on mental health, physical activity can help increase students' capacity for learning;
- physical activity has substantial health benefits for children and adolescents,

including favorable effects on endurance capacity, muscular strength, body weight, and blood pressure; and

- positive experiences with physical activity at a young age help lay the basis for being regularly active throughout life.

DEFINITIONS. For the purposes of this policy:

"Extracurricular activities" refers to school-sponsored voluntary programs that supplement regular education and contribute to the educational objectives of the school.

"Health-related physical fitness" refers to cardiorespiratory endurance, muscular strength and endurance, flexibility, and body composition.

"Interscholastic athletics" refers to organized individual and team sports that involve more than one school.

"Intramurals" refers to physical activity programs that provide opportunities for all students to participate in sport, fitness, and recreational activities within their own school.

"Moderate physical activities" refers to activities that are equivalent in intensity to brisk walking.

"Physical education" refers to a planned, sequential program of curricula and instruction that helps students develop the knowledge, attitudes, motor skills, self-management skills, and confidence needed to adopt and maintain physically active lifestyles.

"Recess" refers to regularly scheduled periods within the school day for unstructured physical activity and play.

"Regular physical activity" refers to participation in moderate to vigorous physical activity for at least 30 minutes per day on most, if not all, days of the week.

"Skill-related physical fitness" refers to balance, agility, power, reaction time, speed, and coordination.

"Vigorous physical activity" refers to exertion that makes a person sweat and breathe hard, such as basketball, soccer, running, swimming laps, fast bicycling, fast dancing, and similar aerobic activities.

2. PHYSICAL EDUCATION

ALL STUDENTS ENROLLED. Every student in each grade, pre-kindergarten through twelfth, shall participate in daily physical education for the entire school year, including students with disabling conditions and those in alternative education programs. Students in the elementary grades shall participate in physical education for at least 150 minutes during each school week, and students in middle schools and high schools shall participate for at least 225 minutes per week.

INSTRUCTIONAL PROGRAM DESIGN. Schools shall establish specific learning goals and objectives for physical education. A sequential, developmentally appropriate curriculum shall be designed, implemented, and evaluated to help students develop the knowledge, motor skills, self-management skills, attitudes, and confidence needed to adopt and maintain physical activity throughout their lives. The physical education program shall:

1. emphasize knowledge and skills for a lifetime of regular physical activity;
2. be consistent with state/district's standards/guidelines/framework for physical education and with national standards that define what students should know and be able to do;
3. devote at least 50 percent of class time to actual physical activity in each week, with as much time as possible spent in moderate to vigorous physical activity;
4. provide many different physical activity choices;
5. feature cooperative as well as competitive games;

6. meet the needs of all students, especially those who are not athletically gifted;
7. take into account gender and cultural differences in students' interests;
8. teach self-management skills as well as movement skills;
9. actively teach cooperation, fair play, and responsible participation in physical activity;
10. have student/teacher ratios comparable to those in other curricular areas;
11. promote participation in physical activity outside of school;
12. focus, at the high school level, on helping adolescents make the transition to an active adult lifestyle; and
13. be an enjoyable experience for students.

Teachers shall aim to develop students' self-confidence and maintain a safe psychological environment free of embarrassment, humiliation, shaming, taunting, or harassment of any kind. Physical education staff shall not order performance of physical activity as a form of discipline or punishment.

Suitably adapted physical education shall be included as part of individual education plans for students with chronic health problems, other disabling conditions, or other special needs that preclude such students' participation in regular physical education instruction or activities.

ASSESSMENT. All students shall be regularly assessed for attainment of the physical education learning objectives. Course grades shall be awarded in the same way grades are awarded in other subject areas and shall be included in calculations of grade point average, class rank, and academic recognition programs such as honor roll.

HEALTH-RELATED FITNESS TESTING. Health-related physical fitness testing shall be integrated into the curriculum as an instructional tool, except in the early elementary grades. Tests shall be appropriate to students' developmental levels and physical abilities. Such testing shall be used to teach students how to assess their fitness levels, set goals for improvement, and monitor progress in reaching their goals. Staff will maintain the confidentiality of fitness test results, which will be made available only to students and their parents/guardians.

As health-related physical fitness is influenced by factors beyond the control of students and teachers (such as genetics, physical maturation, disabling conditions, and body composition), test results shall not be used to determine course grades or to assess the performance of individual teachers.

EXEMPTIONS. Physical education teaches students essential knowledge and skills; for this reason, exemptions from physical education courses shall not be permitted on the basis of participation on an athletic team, community recreation program, ROTC, marching band, or other school or community activity. A student may be excused from participation in physical education only if: 1) a physician states in writing that specific physical activities will jeopardize the student's health and well-being or 2) a parent/guardian requests exemption from specific physical activities on religious grounds.

TEACHING STAFF. Physical education shall be taught by well-prepared specialists who are certified by the state to teach physical education. All physical education teachers shall be adequately prepared and regularly participate in professional development activities to effectively deliver the physical education program. Preparation and professional development activities shall provide basic knowledge of the physical development of children and adolescents combined with skill practice in program-specific activities and other appropriate instructional techniques and strategies designed to promote lifelong habits of physical activity.

ADEQUATE FACILITIES. School leaders shall endeavor to ensure the cost-efficient provision of adequate spaces, facilities, equipment, supplies, and operational budgets that are necessary to achieve the objectives of the physical education program.

School authorities shall minimize the use of physical education facilities for noninstructional purposes, such as using the gymnasium for school assemblies during times scheduled for physical education classes.

EDUCATIONAL REINFORCEMENT. The physical education program shall be closely coordinated with the other components of the overall school health program. Physical education topics shall be integrated within other curricular areas. In particular, the benefits of being physically active shall be linked with instruction about human growth, development, and physiology in science classes and with instruction about personal health behaviors in health education class.

The physical education program shall actively engage families as partners in their children's education and collaborate with community agencies and organizations to provide ample opportunities for students to participate in physical activity beyond the school day.

3. EXTRACURRICULAR PHYSICAL ACTIVITY PROGRAMS

EXTRACURRICULAR PHYSICAL ACTIVITIES. Intramural programs, physical activity clubs, and interscholastic athletics are valuable supplements to a student's education. Schools shall endeavor to provide every student with opportunities to voluntarily participate in extracurricular physical activities that meet his or her needs, interests, and abilities. A diverse selection of competitive and noncompetitive, structured and unstructured activities shall be offered to the extent that staffing permits. The primary focus of extracurricular physical activity programs will be on facilitating participation by all interested students, regardless of their athletic ability. Equal opportunity on the basis of gender shall permeate all aspects of program design and implementation. School leaders shall endeavor to accommodate home-schooled children in extracurricular activities on a budget-neutral basis.

Each extracurricular physical activity program sponsored by in-school and non-school organizations shall be approved by whom and be supervised by a faculty advisor. The integrity and purpose of the physical education program shall not be compromised by such extracurricular activities, nor shall they interfere with the regular school schedule.

EXTRACURRICULAR PROGRAM ELIGIBILITY. School authorities should encourage and support the participation of all students in extracurricular activities, yet such participation is a privilege and not a right. Schools/districts may establish and equitably enforce reasonable eligibility requirements and probationary periods for participation in extracurricular activities. Such requirements may be based on:

- appropriate age;
- enrollment status or residency;
- satisfactory academic performance;
- acceptable attendance record;
- good conduct, including abstinence from the use of tobacco, alcohol, and other harmful drugs;
- agreement to testing for substance abuse;
- suitable health status or physical condition;
- other criteria essential to safety and fairness; or
- the specific requirements of particular activities or sports.

Eligibility requirements and appeal procedures shall be published in a regularly updated student activities handbook that is distributed to students and families annually. Students denied permission to participate in an extracurricular activity shall receive a prompt explanation of the reasons, have an opportunity to respond, and be provided with opportunities to reestablish their eligibility.

A student with a chronic health problem or other disabling condition shall be permitted to participate in any extracurricular activity, including interscholastic athletics, if the student's skills and physical condition meet the same qualifications that all other students must satisfy. The school shall make reasonable accommodations to allow the student to participate.

INTRAMURAL PROGRAMS. Elementary, middle, and high schools shall offer intramural physical activity programs that feature a broad range of competitive and cooperative activities and meet the following criteria:

- students have a choice of activities in which they can participate;
- every student has an opportunity to participate regardless of physical ability; and
- students have the opportunity to be involved in the planning, organization, and administration of the program.

INTERSCHOLASTIC ATHLETICS. High schools shall offer interscholastic athletic programs that shall adhere to the rules and regulations of *appropriate state or local leagues, associations, or conferences*. All coaches, whether volunteer or employed by *school/district*, shall comply with the policies, regulations, rules, and enforcement measures codified in a regularly updated coach's handbook.

Administrators, coaches, and other staff shall model sportsmanlike attitudes and behaviors. Student athletes shall be taught good sportsmanship, such as treating opponents with fairness, courtesy, and respect, and shall be held accountable for their actions. School authorities should evict spectators who do not handle themselves in a sportsmanlike way.

Partnerships between schools and businesses are encouraged, and business sponsorship of athletic teams shall be duly acknowledged. Nevertheless, advertising or other promotional activities supported by commercial interests are not permitted on public school grounds.

REQUIRED RECORDS. The parents or legal guardians of students who choose to participate in intramural programs, interscholastic athletics, or school-linked community recreation programs shall be informed in writing of potential risks associated with a given activity. Schools must keep documentation on file for each participating student that includes:

1. a statement signed by the student's parent/guardian granting permission for the student's participation;
2. emergency contact information for the student's parents/guardians and health care providers;
3. a thorough health appraisal (physical examination) certifying the student's fitness to participate that is appropriate to the activity or sport, conducted within the past 12 months, and signed by a licensed physician;
4. proof of current accident or health insurance coverage; and
5. a release signed by a parent/guardian that absolves the school or district from liability for injuries that may result from participation in school-sponsored physical activities unless negligence on the part of staff or coaches is proven.

FEES. Schools may establish reasonable fees for extracurricular activities and/or interscholastic athletic programs. Students from families who are documented to be financially disadvantaged shall be promptly granted waivers on a confidential basis upon written parental request.

STAFFING. All intramural programs, physical activity clubs, and athletic teams shall be supervised by qualified staff, who may or may not be certified teachers.

Intramural and athletic program staff shall satisfactorily complete courses or other professional development programs that address:

- child and adolescent physical development;

- sports-related injury prevention and safety guidelines;
- infection control procedures;
- first aid and cardiopulmonary resuscitation techniques;
- promotion of healthy student behaviors;
- safe and unsafe methods for youth weight management and conditioning; and
- how to provide students with experiences that emphasize enjoyment, sportsmanship, skill development, confidence building, and self-knowledge.
- Intramural and athletic program staff shall also have satisfactorily completed a supervised probationary period and must regularly participate in relevant staff development programs.
- **VOLUNTEER ATHLETIC AIDES.** Family members and other adult volunteers are encouraged to become involved with extramural or athletic activities. All volunteers shall receive orientation about relevant state, district, and school policies, procedures, and standards of conduct and may be subject to background and reference checks. Volunteer athletic aides shall satisfactorily complete training that addresses, at a minimum:
- basic child and adolescent physical development;
- sports-related injury prevention and safety; and
- first aid and cardiopulmonary resuscitation.

4. OTHER OPPORTUNITIES FOR PHYSICAL ACTIVITY

RECESS IN ELEMENTARY SCHOOLS. Recess provides opportunities for physical activity, which helps students stay alert and attentive in class and provides other educational and social benefits. School authorities shall encourage and develop schedules that provide time within every school day for preschool, kindergarten, and elementary school students to enjoy supervised recess. Every school shall have playgrounds, other facilities, and equipment available for free play. Recess shall complement, not substitute for, physical education classes. Staff shall not deny a student's participation in recess or other physical activity as a form of discipline or punishment, nor should they cancel it for instructional makeup time.

SCHOOL/COMMUNITY COLLABORATION. Schools shall work with recreation agencies and other community organizations to coordinate and enhance opportunities available to students and staff for physical activity during their out-of-school time.

Schools are encouraged to negotiate mutually acceptable, fiscally responsible arrangements with community agencies and organizations to keep school- or district-owned facilities open for use by students, staff, and community members during non-school hours and vacations. School policies concerning safety shall apply at all times.

STAFF PHYSICAL ACTIVITY. The *school/district* shall plan, establish, and implement activities to promote physical activity among staff and provide opportunities for staff to conveniently engage in regular physical activity.

5. SAFETY GUIDELINES

RESPONSIBILITY FOR SAFETY. Minimizing injuries and illnesses related to physical activity is the joint responsibility of everyone: district and school leaders, school staff, students, and their families.

HEALTH AND SAFETY RULES. Schools shall establish rules and procedures concerning safety, infection control, provision of first aid, and the reporting of injuries and illnesses to students' families and appropriate school and community authorities. School administrators shall strictly and consistently enforce compliance with these rules and procedures by all students, school personnel, volunteers, and community members who use school facilities. Students and their families shall be informed of their school's health and safety rules at least annually.

Schools shall require students to use protective clothing and equipment appropriate to the activity and the environment, which will be maintained in good condition. Physical education teachers, coaches, and other athletic personnel and volunteers shall protect students from the effects of extreme weather conditions and endeavor to minimize the amount of exposure to the sun students receive during physical activities.

SAFE FACILITIES. Play areas, facilities, and equipment used for physical activity on school grounds shall meet accepted safety standards for design, installation, and maintenance. Spaces and facilities shall be kept free from violence and exposure to environmental hazards. All spaces, facilities, and equipment used by students and spectators to athletic events shall be thoroughly inspected for health and safety hazards on a regularly scheduled basis, at least twice per year. Written inspection reports shall be kept on file for 10 years. Schools shall correct any hazards before the facilities or equipment may be used by students, staff, or community members.

SUPERVISION. Student physical activity on school grounds during school hours shall be supervised to enforce safety rules and prevent injuries. Supervision shall be by adults trained in first aid, cardiopulmonary resuscitation, and infection control who have easy access to appropriate first aid supplies. Records shall be kept of all injuries and analyzed at least annually so that patterns of causes can be determined and steps can be taken to prevent further injuries.

Supervising adults shall be informed of any relevant medical guidance on file with the school concerning limits on the participation of individual students in physical activity. Such information will be treated with strict confidentiality.

SUBSTANCE USE. School staff and other athletic personnel shall never condone, and must actively discourage, any student use of drugs, steroids, or hormones to enhance appearance or athletic performance. Coaches and athletic trainers shall encourage young people to maintain a healthy diet; practice healthy weight management techniques; and abstain from using tobacco, alcohol, and other drugs.

Existing policies that prohibit drug possession and use shall fully apply to the use or possession of steroids, hormone treatments, and other performance-enhancing drugs. Established policies on student medications shall apply to student consumption or possession of dietary supplements while on school grounds.

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Policies to Encourage Healthy Eating [Tab E]

1. PURPOSE AND GOALS

INTENT. All students shall possess the knowledge and skills necessary to make nutritious and enjoyable food choices for a lifetime. In addition, staff are encouraged to model healthy eating as a valuable part of daily life. School leaders shall prepare, adopt, and implement a comprehensive plan to encourage healthy eating that includes:

- a food service program that employs well-prepared staff who efficiently serve appealing choices of nutritious foods;
- pleasant eating areas for students and staff with adequate time for unhurried eating;
- a sequential program of nutrition instruction that is integrated within the comprehensive school health education curriculum and coordinated with the food service program; that is taught by well-prepared and well-supported staff; and that is aimed at influencing students' knowledge, attitudes, and eating habits;
- an overall school environment that encourages students to make healthy food choices;
- opportunities and encouragement for staff to model healthy eating habits;
- services to ensure that students and staff with nutrition-related health problems are referred to appropriate services for counseling or medical treatment; and
- strategies to involve family members in program development and implementation.

The school nutrition program shall make effective use of school and community resources and equitably serve the needs and interests of all students and staff, taking into consideration differences in cultural norms.

RATIONALE. The link between nutrition and learning is well documented. Healthy eating patterns are essential for students to achieve their full academic potential, full physical and mental growth, and lifelong health and well-being. Healthy eating is demonstrably linked to reduced risk for mortality and development of many chronic diseases as adults. Schools have a responsibility to help students and staff establish and maintain lifelong, healthy eating patterns. Well-planned and well-implemented school nutrition programs have been shown to positively influence students' eating habits.

DEFINITIONS. For the purposes of this policy:

"Competitive foods" refers to any foods or drinks sold or served on school grounds other than meals served by the school food service program.

"Dietary Guidelines for Americans" refers to the current set of recommendations of the federal government that are designed to help people choose diets that will meet nutrient requirements, promote health, support active lives, and reduce chronic disease risks.

"Nutrition education" refers to a planned sequential instructional program that provides knowledge and teaches skills to help students adopt and maintain lifelong healthy eating patterns.

2. NUTRITION EDUCATION

INSTRUCTIONAL PROGRAM DESIGN. Nutrition education topics shall be integrated within the sequential, comprehensive health education program taught at every grade level, pre-kindergarten through twelfth. The nutrition education program shall focus on students' eating behaviors, be based on theories and methods proven effective by published research, and be consistent with the *state's/district's* health education *standards/guidelines/framework*. Nutrition education shall be designed to help students learn:

- nutritional knowledge, including but not limited to the benefits of healthy eating, essential nutrients, nutritional deficiencies, principles of healthy weight management, the use and misuse of dietary supplements, and safe food preparation, handling, and storage;
- nutrition-related skills, including but not limited to planning a healthy meal, understanding and using food labels, and critically evaluating nutrition information, misinformation, and commercial food advertising; and
- how to assess one's personal eating habits, set goals for improvement, and achieve those goals.

Nutrition education instructional activities shall stress the appealing aspects of healthy eating and be participatory, developmentally appropriate, and enjoyable. The program shall engage families as partners in their children's education.

The school health council shall assess all nutrition education curricula and materials for accuracy, completeness, balance, and consistency with the *state's/district's* educational goals and standards. Materials developed by food marketing boards or food corporations shall be examined for inappropriate commercial messages.

STAFF QUALIFICATIONS. Staff responsible for nutrition education shall be adequately prepared and regularly participate in professional development activities to effectively deliver the nutrition education program as planned. Preparation and professional development activities shall provide basic knowledge of nutrition, combined with skill practice in program-specific activities and instructional techniques and strategies designed to promote healthy eating habits.

EDUCATIONAL REINFORCEMENT. School personnel shall not offer food as a performance incentive or reward and shall not withhold food from students as punishment.

Nutrition instruction shall be closely coordinated with the food service program and other components of the school health program. Nutrition concepts shall be integrated into the instruction of other subject areas.

School instructional staff shall collaborate with agencies and groups conducting nutrition education in the community to send consistent messages to students and their families. Guest speakers invited to address students shall receive appropriate orientation to the relevant policies of *school/district*.

School staff are encouraged to cooperate with other agencies and community groups to provide opportunities for student volunteer work related to nutrition, such as assisting with food recovery efforts and preparing nutritious meals for house-bound people. School officials should also disseminate information to parents, students, and staff about community programs that offer nutrition assistance to families.

STAFF AS ROLE MODELS. School staff are encouraged to model healthy eating behaviors. Schools should offer wellness programs that include personalized instruction about healthy eating and physical activity.

3. THE FOOD SERVICE PROGRAM

INTENT. The *state legislature/state board/local school board* acknowledges that the feeding of children is primarily a family responsibility. To supplement their efforts, every school shall operate a food service program to ensure that all students have affordable access to the varied and nutritious foods they need to stay healthy and learn well.

The food service program shall aim to be financially self-supporting. However, the program is an essential educational and support activity and budget neutrality or profit generation must not take precedence over the nutritional needs of students.

PROGRAM REQUIREMENTS. During each school day the school food service program shall offer breakfast and lunch as well as snacks for students in organized after-school education or enrichment programs. Each school shall encourage all students to participate in these meal opportunities. In particular, the school shall make efforts to ensure that families are aware of need-based programs for free or reduced-price meals and that eligible families are encouraged to apply. The program shall maintain the confidentiality of students and families applying for or receiving free or reduced-priced meals.

The school food service program shall operate in accordance with the National School Lunch Act and the Child Nutrition Act of 1996 as amended and applicable laws and regulations of *state*. Schools shall offer varied and nutritious food choices that are consistent with the federal government's Dietary Guidelines for Americans. Menus should be planned with input from students, family members, and other school personnel and should take into account students' cultural norms and preferences. Food-pricing strategies shall be designed to encourage students to purchase nutritious items. Procedures shall be in place for providing to families, on request, information about the ingredients and nutritional value of the foods served.

Upon a physician's written request, modified meals shall be prepared for students with food allergies or other special food needs. Information on the ingredients used in preparation of school meals shall be provided to parents upon request. Parents shall be notified about this option.

All food service equipment and facilities must meet applicable local and state standards concerning health; safe food preparation, handling, and storage; drinking water; sanitation; and workplace safety.

Staff shall cooperate with efforts in the community to recover wholesome excess food for distribution to people in need.

EATING AS A POSITIVE EXPERIENCE. Students and staff shall have adequate space to eat meals in pleasant surroundings and shall have adequate time to eat, relax, and socialize: at least 10 minutes after sitting down for breakfast and 20 minutes after sitting down for lunch. Safe drinking water and convenient access to facilities for hand washing and oral hygiene shall be available.

STAFFING. Each *district/school* shall employ a food service director, who is properly qualified and certified according to current professional standards, to administer the school food service program and satisfy reporting requirements.

All food service personnel shall have adequate preservice training and regularly participate in professional development activities that address strategies for promoting healthy eating behavior, food safety, and other topics directly relevant to the employee's job duties.

Dining room supervisory staff shall receive appropriate training in how to maintain safe, orderly, and pleasant eating environments.

CONTRACTED SERVICES. Specified elements of the school food service program may be contracted out to food service management companies or other vendors following established open bidding procedures. The contractor(s) shall fully comply with the nutritional standards established by the U.S. Department of Agriculture (USDA) for school food programs and be subject to district auditing processes. *District/school official* shall be responsible for administering the contract. The district retains the responsibility for meeting all USDA requirements.

COORDINATION WITH OTHER PROGRAMS. The food service program shall be closely coordinated with nutrition instruction to allow students to apply critical thinking skills taught in the classroom. Food service staff shall also work closely with those responsible for other components of the school health program to achieve common goals.

A child's need for nutrients does not end when school does. Schools are encouraged to offer meals during breaks in the school calendar and to coordinate with other agencies and community groups to operate, or assist with operating, a summer food service program for children and adolescents who are eligible for federal program support.

4. OTHER FOOD CHOICES AT SCHOOL

NUTRITIOUS FOOD CHOICES. Nutritious and appealing foods, such as fruits, vegetables, low-fat dairy foods, and low-fat grain products, shall be available wherever and whenever food is sold or otherwise offered at school. Schools shall take efforts to encourage students to make nutritious food choices.

Food and beverages sold or served on school grounds or at school-sponsored events shall meet nutritional standards and other guidelines set by the state/district/school health council/nutrition committee. This includes:

- à la carte offerings in the food service program;
- food and beverage choices in vending machines, snack bars, school stores, and concession stands;
- food and beverages sold as part of school-sponsored fundraising activities; and
- refreshments served at parties, celebrations, and meetings.

FOOD SALES. The sale of all foods on school grounds shall be under the management of the school food service program, except foods sold as part of a fundraising activity. In middle and high schools, food and beverages shall not be sold from vending machines or school stores during school hours/until 30 minutes after the end of the last lunch period unless they are part of the school food service program. Profits generated from sales of foods or beverages in vending machines or school stores will accrue to the food service program/student organizations approved by whom.

Only student organizations and legally constituted, nonsectarian, nonpartisan organizations approved by whom are permitted to engage in fundraising on school grounds at any time. These organizations are encouraged to raise funds through the sale of items other than food. Foods sold for fundraising purposes shall not be sold while school food service meals are being served. Each organization raising funds by selling foods is limited to one event per month during school hours.

Elementary school students shall not have access to food or beverages sold in vending machines or school stores.

CLOSED CAMPUS. Students are not permitted to leave school grounds during the school day to purchase food or beverages.

COMMERCIAL ADVERTISING. Partnerships between schools and businesses are encouraged, and business sponsorship of educational activities and materials shall be duly acknowledged. However, such partnerships shall be designed to meet identified educational needs, not commercial motives, and shall be evaluated for educational effectiveness by the school/district on an ongoing basis.

5. SERVICES FOR NUTRITION-RELATED HEALTH PROBLEMS

NUTRITION-RELATED HEALTH PROBLEMS. School counselors and school health services staff shall consistently promote healthy eating to students and other staff. These professionals shall be prepared to recognize conditions such as obesity, eating disorders, and other nutrition-related health problems among students and staff and be able to refer them to appropriate services.

Policies to Discourage Tobacco Use [Tab F]

1. PURPOSE AND GOALS

INTENT. All students shall possess the knowledge and skills necessary to avoid all tobacco use, and school leaders shall actively discourage all use of tobacco products by students, staff, and school visitors. To achieve these ends, district/school leaders shall prepare, adopt, and implement a comprehensive plan to prevent tobacco use that includes:

- a sequential educational program to prevent tobacco use that is integrated within the school health education curriculum; that is aimed at influencing students' attitudes, skills, and behaviors; and that is taught by well-prepared and well-supported staff;
- establishment and strict enforcement of completely tobacco-free school environments at all times;
- prohibition of tobacco advertising;
- appropriate counseling services and/or referrals for students and staff to help them overcome tobacco addiction;
- cooperation with community-wide efforts to prevent tobacco use; and
- strategies to involve family members in program development and implementation.

RATIONALE. Cigarette smoking is considered the chief preventable cause of premature disease and death in the United States. Schools have a responsibility to help prevent tobacco use for the sake of students' and staff members' health and the well-being of their families. Research conclusively proves that:

- regular use of tobacco is ultimately harmful to every user's health, directly causing cancer, respiratory and cardiovascular diseases, adverse pregnancy outcomes, and premature death;
- second-hand smoke is a threat to the personal health of everyone, especially persons with asthma and other respiratory problems;
- nicotine is a powerfully addictive substance;
- tobacco use most often begins during childhood or adolescence;
- the younger a person starts using tobacco, the more likely he or she will be a heavy user as an adult; and
- many young tobacco users will die an early, preventable death because of their decision to use tobacco.

Additional reasons why schools need to strongly discourage tobacco use are that:

- the purchase and possession of tobacco products is illegal for persons under age 18 [*depending on the state*];
- use of tobacco interferes with students' attendance and learning;
- smoking is a fire safety issue for schools; and
- use of spit tobacco is a health and sanitation issue.

DEFINITION. For the purposes of this policy "tobacco" is defined to include any lighted or unlighted cigarette, cigar, pipe, bidi, clove cigarette, and any other smoking product, and spit tobacco, also known as smokeless, dip, chew, and snuff, in any form.

2. TOBACCO-FREE ENVIRONMENTS

TOBACCO USE PROHIBITED. No student, staff member, or school visitor is permitted to smoke, inhale, dip, or chew tobacco at any time, including non-school hours:

- in any building, facility, or vehicle owned, leased, rented, or chartered by the state/district/school;
- on school grounds, athletic grounds, or parking lots; or
- at any school-sponsored event off campus.

In addition, no student is permitted to possess a tobacco product. The provisions of existing policies that address the use and possession of drugs shall apply to all tobacco products.

TOBACCO PROMOTION. Tobacco promotional items, including clothing, bags, lighters, and other personal articles, are not permitted on school grounds, in school vehicles, or at school-sponsored events. Tobacco advertising is prohibited in all school-sponsored publications and at all school-sponsored events.

CLOSED CAMPUS. No student may leave the school campus during breaks in the school day to use a tobacco product. Signs to this effect will be posted at appropriate locations. School authorities shall consult with local law enforcement agencies to enforce laws that prohibit the possession of tobacco by minors within the immediate proximity of school grounds.

NOTICE. The superintendent/principal/other shall notify students, families, education personnel, and school visitors of the tobacco-free policy in handbooks and newsletters, on posted notices or signs at every school entrance and other appropriate locations, and by other efficient means. To the extent possible, schools and districts will make use of local media to publicize the policies and help influence community norms about tobacco use.

ENFORCEMENT. It is the responsibility of all students, employees, and visitors to enforce this policy through verbal admonition. Any tobacco product found in the possession of a minor student shall be confiscated by staff and discarded. Students and employees also may be subject to germane sanctions as determined by written school policy, including disciplinary action. All school staff shall participate in training on the correct and fair enforcement of tobacco-free policies.

3. TOBACCO-USE PREVENTION EDUCATION

INSTRUCTIONAL PROGRAM DESIGN. Tobacco-use prevention education shall be integrated within the health education program and be taught at every grade level, pre-kindergarten through twelfth. The educational program shall be based on theories and methods that have been proven effective by published research and consistent with the state's/district's/ school's health education standards/guidelines/framework. The program shall be designed to:

1. instruct about immediate and long-term undesirable physiologic, cosmetic, and social consequences of tobacco use;
2. decrease the social acceptability of tobacco use;
3. address reasons why young people smoke;
4. teach how to recognize and refute advertising and other social influences that promote tobacco use;
5. develop students' skills for resisting social influences that promote tobacco use; and
6. develop necessary assertiveness, communication, goal-setting, and problem-solving skills that may enable students to avoid tobacco use and other health-risk behaviors.

Instruction shall be most intensive in grades six through eight and shall be reinforced in all later grades. Instructional activities shall be participatory and developmentally appropriate. The program shall engage families as partners in their children's education.

STAFF PREPARATION. Staff responsible for teaching tobacco-use prevention shall have adequate preservice training and participate in ongoing professional development activities

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to effectively deliver the education program as planned. Preparation and professional development activities shall provide basic knowledge about the effects of tobacco use combined with skill practice in effective instructional techniques and strategies and program-specific activities.

EDUCATIONAL REINFORCEMENT. Tobacco-use prevention education shall be closely coordinated with the other components of the school health program. Tobacco-use prevention concepts shall also be integrated into the instruction of other subject areas to the greatest extent possible.

To send consistent messages to students and their families, school instructional staff shall collaborate with agencies and groups that conduct tobacco-use prevention education in the community. Guest speakers invited to address students shall receive appropriate orientation to the relevant policies of the *school/district*. School staff shall also help interested students become involved with agencies and other organizations in the community that are working to prevent tobacco use.

4. ASSISTANCE TO OVERCOME TOBACCO ADDICTION

PROGRAM AVAILABILITY. The school health program shall include referrals to community resources and programs to help students and staff overcome tobacco addiction. School counselors or community agencies are encouraged to establish voluntary tobacco-use cessation programs at school.

PROGRAM ATTENDANCE. Attendance or completion of a tobacco-use cessation program shall not be mandatory for anyone or used as a penalty. Attendance or completion of a tobacco-use cessation program is allowed as a voluntary substitute to suspension for possession or use of tobacco.

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References

[1] Centers for Disease Control and Prevention, "Leading causes of mortality and morbidity and contributing behaviors in the United States," undated. Available at www.cdc.gov/nccdphp/dash/ahsumm/ussumm.htm.

[2] National Association of State Boards of Education, *The Future Is Now: Addressing Social Issues in Schools of the 21st Century*, 1999.

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B. The Art of Policymaking

People who are not already involved in making policy might find the process puzzling or daunting. The process can appear to be inherently ad hoc, as the procedures vary considerably from place to place, from time to time, and from one situation to another.

Admittedly, there is no standard process for developing education policy on school health—or on any other topic. Nevertheless, for those who want to advance school health goals, there are some general procedures involved in the "art" of making education policy. These methods generally apply to both the public and private education sectors.

This chapter provides a basic orientation for those who want to engage in the policymaking process and advance educational goals related to health. A chapter table of contents appears on the following page.

If the Board Knows What It Wants

Ambiguity, confusion, and trouble are avoided when policies are adopted and published. Clearly written policies that reflect thorough research, sound judgment, and careful planning stave off the maiming accusions of uninformed critics.

It is nonsense to think that you have to be a combination of a corporation lawyer, a visionary, and a Thomas Jefferson before you can venture to write policy. If the [school] board knows what it wants, and can communicate those wants in clear, concise English, it can write policy. It is surprising how much thoughtful policy work gets done if the board will routinely set aside part of every meeting to discuss policy issues rather than immediate needs.

—National School Boards Association[1]

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1. What Is "Policy"?

Education policies are official statements of vision and judgment that address the needs of a state, district, or school. Policies, and the process used to develop or revise them, are valuable for providing the following:

- **Leadership:** Policies are the means by which authority and influence are expressed: the tangible results of leadership. As they craft policy, education leaders can demonstrate the value of knowledge, principle, and experience and reassure the public that school authorities are competently addressing critical topics.
- **Commitment:** Adoption of a policy is a declaration by decision makers that an issue is important and must be addressed.
- **Support:** Teachers and administrators frequently cite the need for policies that endorse the value of their activities— particularly in the area of school health— so they can practice their professions with confidence.
- **Direction:** Policies can drive change— or they can help keep the system on a steady course.
- **Guidance:** Policies based on current scientific, medical, and legal information can clarify issues for teachers and administrators and lay out options for action. Good policies anticipate challenging situations and can help prevent confusing or haphazard responses.
- **Institutionalization:** Written policies can help integrate new programs and processes into ongoing school activities.
- **Public engagement:** The policy adoption process can increase public knowledge about facts, issues, and applicable laws. A good process for developing policy considers a variety of viewpoints and thereby builds support for implementing the policy.
- **Accountability:** Policies typically state who is responsible for doing what and how performance is measured.
- **Legal protection:** Sound policy helps to prevent abuses that are grounds for legal action.

A sound policy foundation is particularly important for school health programs intended to prevent long-term chronic health problems because the benefits to students and their families might not be immediately apparent.

Policy has important limitations. Establishing a good policy is seldom enough to accomplish an educational goal on its own. People act— or do not act— according to many factors other than what an official policy requires; there are always many ways to get around a mandate. Sound policy needs to be supplemented by effective management, adequate training and technical assistance, and good staff morale. Establishing a policy should be just one aspect of an overall action plan that outlines objectives, actions to be taken, task assignments, timetables, and necessary resources.

Types of policy

The term *policy* can cause confusion because different people take it to mean different things. In general, policies tend to be sweeping statements adopted by authoritative governing bodies such as state legislatures and state and local boards of education. More specifically, a state, school district, or school may be governed by legal codes, rules, standards, administrative orders, guidelines, mandates, resolutions, or other means of exercising authority—all are types of policy. To confuse matters more, policy often takes a different form depending on the situation, jurisdiction, or level. In this guide policy is used in a broad, generic sense to mean *officially determined objectives that guide the actions of students and employees in the education system*.

Policymakers usually have a choice of various types of policy tools to effect change (see box, "Change Levers Used by Policymakers"). Institutions and traditions that are unique to a given place—"this is how we do things around here"—greatly influence the type of policy instrument used.

For example, the state board of education in a strong "local control" state might issue a *nonbinding resolution* in an attempt to influence local decision making, whereas another state board may use *financial incentives* to encourage voluntary compliance, and a third could decree a *rule* that all must follow.

Policies typically express *what* should be done, *why* it should be done, and *who* should do it. Regulations and procedural guidelines governing day-to-day work outline the details of *how* to accomplish a policy's goals. Policymakers should let such administrative guidance be determined by trusted administrators and managers and avoid "micromanaging."

Change Levers Used by Policymakers

State	Local	Policy tool
✓	✓	Statement of vision and goals
✓	✓	Academic content and performance standards
✓	✓	Curriculum frameworks
✓		School accreditation standards
✓	✓	Required courses and graduation units
✓	✓	Approved textbook lists
✓	✓	Staff preparation and professional development requirements
✓		Certification of teachers, administrators, and others
✓	✓	Policies that address specific issues
✓	✓	Tests and other assessments
✓	✓	Resolutions and position statements
✓	✓	Training and technical assistance
✓	✓	Policy samples, guidelines, and other information
✓	✓	Advocacy for specific policies, legislation, programs, and resources
✓	✓	Budget priorities and line items
✓	✓	Program performance evaluation standards
✓	✓	Public engagement around the issues
✓	✓	Data collection to inform policy and program decisions
✓	✓	Public awareness campaigns

The policy samples included in this guide are deliberately written in broad language; administrators are expected to be able to translate policies into specific action steps with the technical assistance of school health professionals and their membership organizations. This policy guide does not

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State Policies That Support Local Programs

State policies and programs can encourage and support local districts to initiate and sustain school health programs. Such policies might include, among others:

- **policies and programs that support comprehensive services for children, youth, and families delivered in an interagency, interdisciplinary, collaborative manner;**
- **appropriations to fund school health and interagency programs;**
- **accountability systems that provide information on the extent to which students have adequate knowledge about health-related issues and/or exhibit positive health behaviors; and**
- **state certification and licensure requirements to ensure that school professionals are cognizant of the importance of students' health and of their roles in health promotion.**

provide operational details about how to plan and manage all the components of a school health program.

Where policy is made

Whether a given policy is most appropriate at the state, regional school district, tribal, local school district, or individual school level depends on the topic and the governing context.

State officials who develop the policies that govern local school districts generally try to respect the principle of local control. States are silent on many issues and allow local districts freedom to address those issues as they see fit. Most aspects of school health programs traditionally have been among those issues left up to local decision makers. However, as the value and importance of school health programs have received greater recognition in recent years, more and more states are adopting policies in this area.

Constitutionally, the ultimate responsibility for public education lies with state government; local school boards are technically their agents (see the discussion on "Who's Who in Education Policymaking" later in this chapter). Recently, many states have been shouldering an increasing proportion of education expenditures and are in return demanding greater accountability for students' academic performance results.

Nevertheless, despite states' legal authority the extent to which local districts comply with state policies can vary considerably. Compliance might depend on the political climate or on the state's capacity to fund local programs, provide assistance in meeting state policies, monitor local district and school performance, or enforce policy directives.

Users of this guide undoubtedly will have to adapt the sample policies to fit their own education governance system. Some concepts might be more appropriate at the state level, and others may be local concerns. Many concepts can be usefully enshrined at *all* levels. The sample policies in this guide are written so that any public education policymaking body at the state, district, or school level should be able to easily adapt them with the advice and assistance of an attorney who is familiar with applicable state and local education laws.

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Resource

- *Becoming a Better Board Member: A Guide to Effective Board Service* (1996) from the **National School Boards Association** is a compendium of advice and information to help school board members become more effective in governing public education. Call (703) 838-NSBA.

2. The Policy Development Process

Every policy development process has a different history, with its own milestones, pace, and timeline. A process and the politics that surround it can vary tremendously depending on organizational arrangements, individual personalities, and many other factors. Nevertheless, there are five common tasks that anyone shepherding a process usually must accomplish:

1. lay the groundwork;
2. build awareness and support;
3. draft the policy;
4. adopt the policy; and
5. administer the policy.

Task 1. Lay the groundwork

Anyone can initiate a process to create new or to revise existing education policies: a school board member, administrator, teacher, other school staff member, student, family member, health professional, or anyone else in the community. The effort can be motivated in response to a pressing concern, by a decision to be ready for possible problems that might arise, or simply by a desire to "do the right thing." The following steps usually need to be accomplished to lay the groundwork for a policy initiative:

- ✓ **Clarify the need.** Assess the conditions that warrant the proposed policies. Conduct a formal or informal needs assessment. Compile available education and health statistics, such as data from the local health department or results from CDC's Youth Risk Behavior Survey if it is administered in the state or district. Survey what families say they want for their children; preparing children to live healthy lifestyles is often among parents' top priorities.
- ✓ **Clarify the objective.** Be sure to check whether another policy or program is already addressing the issue to any extent. Determine if a new policy is needed, or if an existing policy can be revised and improved. It may be easier for policymakers to rework a current policy than to adopt a new one.
- ✓ **Review the "foundation" policies.** Become familiar with the process and procedures usually used to develop and pass a policy. The policy development process itself might need some refinement before proceeding with a school health policy initiative (see box, "First Things First: Foundation Policies," on the following page).
- ✓ **Collect information.** Assemble information about current scientific and medical findings; useful resource materials; relevant federal, state, local, and/or tribal laws and regulations; sample policies; and examples of successes elsewhere. For assistance, call on colleagues, local community experts, and state and national agencies and organizations that are listed as resources in this guide.

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✓ **Brainstorm concrete activities or programs.** Gather ideas from school staff and read the suggestions contained in this guide. Be open to ideas for filling gaps, meeting needs, solving problems, and making essential improvements. Any proposed policies and programs must be consistent with community standards and sensitive to the racial, ethnic, and cultural diversity in today's schools. Policies tend to be most effective when they are homegrown and reflect the unique characteristics and circumstances of the state, district, and community.

✓ **Write a policy proposal.** Based on the information collected, write a brief description of the issues. Identify the educational, health, and economic reasons for adopting a new policy or revising an existing one. Outline several policy options from which decision makers can choose. The financial implications of any proposed school health policy must not be overlooked.

Education decision makers who must continually address an overwhelming number of concerns may be reluctant to add school health issues to their already full agenda unless they think the problem is urgent and can be effectively addressed at an acceptable cost. It is critically important to do the homework and have the facts straight, as one major inaccuracy could seriously injure the credibility or momentum of an entire initiative.

✓ **Become familiar with the political dynamics.** Topics that seem fairly straightforward can raise unexpected passions in the community, such as school vending machine guidelines, academic requirements for athletes, or a ban on smoking at school athletic events. Learn about the predilections of key policymakers and the relationships among them. Find out how various factions, if any, maneuver to influence policy. Anticipate who is likely to be supportive and who will oppose the policy proposals.

The best way to learn how to work effectively with education policymakers in any given arena is to ask

First Things First: Foundation Policies

Before embarking on the road to new school health policies, the existing policy development process should be critically assessed. It might be prudent to revisit the foundation policies that govern the procedure, such as:

- **a *vision statement*, which expresses an educational philosophy spelling out the need to address students' overall mental, social, and physical growth and development and which recognizes that the schools have a valid role in protecting the health of the general public (the following chapter offers a sample vision statement);**
- ***procedural policies* that define the necessary participants in the policymaking process, along with protocols, timelines, and means for involving the public;**
- **the appointment of a *school health council*, which encourages family and community members to provide input and exercise judgment; and**
- ***rules* governing public meetings and hearings, such as guidelines for speakers' conduct and time limits for presentations.**

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someone "in the know." A personal friend may be able to provide a connection to an insider who can offer candid information and advice.

- ✓ **Devise an appropriate strategy to get a policy adopted/revised.** Seek advice on the best ways to approach individual policymakers or the policymaking body as a whole. Ascertain who should introduce issues to various key players and who should make policy recommendations. Find out who is particularly respected and how much influence is held by parent organizations, unions and professional associations, school councils, and other key bodies.

  Depending on the state of current policies and people's attitudes, incremental "baby steps" might be more appropriate at a given time than a major push for a comprehensive set of ideal policies. Some complex topics might need extra time for extensive study or for building community support. Determining what is politically feasible requires good judgment and an understanding of the school and the community.

- ✓ **Respect the hierarchy.** Most administrators dislike surprises and want to be kept informed about proposed policy initiatives that a board might be asked to address. An eager school health professional who works with a board member "behind the back" of the principal or superintendent might create a new set of problems to overcome.

- ✓ **Do not expect quick or easy victories.** School health advocates who have enjoyed considerable success at getting policies passed nevertheless report that their accomplishments took more effort and much more time than they had anticipated. Be patient yet persistent: "The wheels of government turn slowly."

Task 2. Build awareness and support

Arguably the most important step in crafting any school health policy is to enlist widespread backing for its goals and strategies. Education policymaking in the United States is grounded in democracy, and policies must reflect local opinions and priorities. To a great extent a policy's quality and usefulness depends on who proposes it and who supports it.

It may seem self-evident that high-quality school health programs help children learn better. Yet some education policymakers, educators, and influential people in the community may not think school health programs are necessary. Many are concerned about burdening schools with social goals and diverting time and resources away from academic learning. Others do not have a clear understanding of the intent and substance of school health programs or believe the programs wastefully duplicate existing health services. Justifications for school health programs need to address such doubts.

Even if it appears that the state or community is likely to support new school health policies, such backing cannot be taken for granted. Support often needs to be actively demonstrated during the policymaking process. Even the most

Tips for Engaging Policymakers

- Note serious problems and needs but emphasize proposed solutions and policy options;
- From the outset, be forthcoming about anticipated costs;
- Articulate measurable, short-term benefits, such as effects on student and staff attendance:
- Use current data from credible sources as justification;
- Stress how the proposal is consistent with existing policies and programs and sustains the board's policy goals;
- Use current terminology frequently used by policymakers, such as "education reform," "ready to learn" and "student achievement";
- Highlight school health as an emerging trend that more and more boards are supporting (the "bandwagon effect");
- Enlist the endorsement of the business community;
- Suggest a pilot study if a broad-based policy or program does not gain support; and
- Make presentations at meetings and conferences that policymakers are likely to attend.

proactive policymaker needs a solid base of support in the community before he or she can get a new policy initiative enacted.

On the other hand, depending on the issue and political context, it may or may not be prudent to publicize the policy initiative early in the policymaking process. Savvy political judgment is necessary. For guidance, consult with someone "in the know."

Following are some concrete action steps that can help build widespread support for school health policies:

✓ **Involve those affected by the policy.** No education policy is likely to be effectively carried out without a significant degree of buy-in and acceptance from those who are expected to implement it. School staff, parents, students, and others who will be affected by a policy need to actively participate in its development, revision, or review.

✓ **Involve other youth-serving agencies in the community.** This will improve the coordination of different efforts and increase consistency among prevention messages. Such agencies include the YMCA, YWCA, 4-H, and Boys & Girls Clubs; recreation departments; social services agencies; and religious organizations.

✓ **Involve people from a variety of community groups.** Although it takes time to conduct an inclusive policy process that considers many viewpoints, the time and energy used to develop broad support are worthwhile investments. The best advocates for school health programs often come from outside education. Key constituencies include:

- *Health providers* such as physicians, nurses, pharmacists, and their professional organizations; health clinic administrators and staff; mental health practitioners; and child welfare agency staff.
- Influential *community groups and individuals* such as local chapters of the American Cancer Society, the American Heart Association, the American Lung Association, the

American Red Cross, who may be conducting community health promotion efforts; plus other voluntary organizations; fraternal organizations (e.g., Elks and Lions Clubs, VFW groups); religious groups; and seniors' organizations.

- *Business leaders,* who are often influential in the education reform debate. They can help spread the word about the importance of school health programs and influence key policymakers. Many companies are interested in supporting causes that create goodwill in the community and enhance their corporate image through increased media coverage. Employers also may have school-age children or grandchildren.
- *Private sector employees,* many of whom have school-age children. They often play a large role in determining internal corporate priorities for community action. Their discussions both inside and outside the workplace can help spread the word about the need for school health programs. Focus group research indicates that most employees think schools should promote health education.[3]

✓ **Anticipate, respond to, and involve critics.** Policymakers need to be made aware of potential opponents and possible controversies that could arise during the policymaking process. They might want speaking points provided in advance that they could use to respond to critics. Inviting selected opponents into the policymaking process can have positive results. Their constructive criticism could strengthen the proposed policy. They might even be persuaded by the evidence presented to support the effort.

✓ **Apply communications strategies as needed** to increase public awareness of the need for the proposed policy. Policymakers are more likely to be attentive if a groundswell of public support is generated. How to accomplish this is discussed later in this chapter.

The Bottom Line: The Law

> **If a legal challenge is ever mounted to a school district's actions...it will be based upon knowledgeable...evidence, not upon the pooling of opinions.... [An] unsound policy will not be upheld in court regardless of how fervently it is believed and supported, how large and highly diversified the development committee, or how democratic the process.**
>
> **—Douglas Bates, Utah School Law and Legislation Coordinator[2]**

Task 3. Draft the policy

The policy-drafting process can be more than just a work task: it can be an educational activity for policymakers, staff, and involved community members. The process can help build bridges of respect among those with dissimilar viewpoints and constituencies. Participation in the give-and-take discussions can increase their understanding of the many factors policymakers must balance. Following are steps to take in crafting a policy:

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Typical Policy Components

Authority: Who is establishing the policy; what legal authority underlies it.

Rationale: Why this policy is necessary.

Priority population: To whom the policy applies.

Definitions: To avoid confusion, include clear explanations of major terms used.

Activities: The heart of the policy that describes a program to be conducted, the strategy to deal with a particular situation, and requirements that staff must follow.

Administration: Who enforces the policy and how.

Consequences: The rewards and sanctions that provide positive and negative incentives for compliance with the policy.

Evaluation: How the policy's effect will be measured and how that information will be used.

Duration: When the policy is adopted, when it takes effect, and when it expires.

✓ **Officially bring the policy proposal to the attention of the decision-making body** (e.g., the state or local school board) for the go-ahead to proceed. Use established procedures for introducing new policy ideas. Suggest who should work to draft the policy. A school health council is a natural policy-drafting committee. Its backing can help build a broad base of community understanding and support. If such a committee does not already exist, a special task force can be appointed to draft policies. To the extent possible, any policy-drafting body should include:

- parents, guardians, and/or family members of students;
- teachers and administrators;
- school health staff, pupil services personnel, food service personnel, and other school staff;
- middle or high school students, who might provide a useful reality check; and
- a broad range of community representatives with diverse perspectives.

Note that a collective bargaining agreement also might require that an official (not just a member) of the teachers' association or school employee union be involved in the policy development process.

✓ **Prepare for the board's consideration** a clearly written charge to the policy-drafting committee, with a specific action timeline. Identify a staff professional or someone else who can provide research and writing support to the policy-drafting committee.

✓ **Conduct study sessions** on the facts, the major policy options, and any relevant legal parameters. Arrange for short presentations by credible experts with ample opportunities for policy-drafting committee members to pose questions and express their concerns and perspectives.

✓ **Stay focused on the "big picture."** As the fine points of the proposed policy are being worked out, sometimes the old adage can be true: "The devil is in the details." If it becomes difficult to find an acceptable balance among competing interests or policy objectives, re-focus the discussion on the overall policy goals and the best interests of children and youth.

✓ **Draft the policy language,** drawing on the information gathered and the values and experiences of committee members. Some guiding principles:

- use language that is simple, clear, specific, and accurate; avoid education, health, and legal jargon;
- be concise and brief;
- include a rationale for the policy; describe the benefits of adopting it;

Characteristics of Good Policy Research

It can be difficult and confusing for nonspecialists to determine whether research findings are sound. Lay policymakers can sort through competing research studies by asking a few critical questions:

Objectivity:

- Is the research or evaluation organization considered credible within the research community? Is its work perceived to be objective?
- Do the researchers show evidence of preexisting bias or a policy agenda? If so, are they honest about their assumptions up front?
- Was the research published in a scientific or academic journal? Has it been cited by a reputable policy organization?

Study Design:

- Do the research questions address real problems?
- Is the research well organized, and does it find answers to critical questions?
- Is the population sample studied large enough and diverse enough to justify drawing broad conclusions?
- Does the study include a "control group" that is equivalent to the "experimental group" except for the "treatment" being studied? Is assignment to the control and experimental groups random? Are the students who are being studied matched on critical characteristics?
- When evaluating case studies ask: Are the site selection criteria and methods for collecting and analyzing data consistent with the purpose of the research? Is there an organized strategy for collecting information that ensures consistency among different individual researchers? Are multiple methods used to collect and analyze information?

Review:

- Have other researchers not involved in the study critically reviewed it (peer review)?
- Have other researchers duplicated the research?

Plausibility:

- Are the results convincing?
- Do the results make sense?

If a research study that appears to be sound is nevertheless attacked or discounted, its opponents should be challenged to provide alternative data or research evidence that can then be subjected to the same tests of quality.

—National Association of State Boards of Education[4]

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- be consistent with state, district, and school visions for student learning, education reform efforts, and other current initiatives;
- build in accountability—cite who will be held responsible for doing what and describe mechanisms for ongoing enforcement;
- ensure that the policy provides practical guidance to school staff members about how to address specific issues; and
- include provisions for policy evaluation and periodic review.

An attorney who is familiar with state and local education laws should always review draft policies to ensure conformance with applicable legal parameters and governance structures.

User-Friendly Formats

Information is often most useful to decision makers (and news agencies) when:

- **brief *oral presentations* cover only the most important points, accompanied by a written summary;**
- **documents are as *succinct* as possible without sacrificing accuracy or context;**
- **research *summaries* are prepared on major policy questions that address disparate findings in a balanced way;**
- **information is *clearly written* in language that policymakers, parents, and other laypersons can understand (i.e., a minimum of academic or public health jargon);**
- ***charts and graphs* illustrate key findings;**
- **the information is *timely;* and**
- ***definite conclusions and policy options* are presented.**

Selected, well-referenced statistics can be used in a policy to strengthen its justification. This can be valuable in the short run if the policy is expected to be controversial or if the policy is to be used to educate as well as guide action. A disadvantage, however, is that statistics can make a policy look out-of-date after only a few years. (The sample policies provided in this guide assert proven findings in general terms that are likely to stand the test of time.)

✓ **Allow time** for committee members to share the draft policies with their constituencies, gather reactions, and report back to the full committee.

✓ **Conduct public hearings** or other means of gathering public input as required by the established policymaking procedures. To develop broad-based support and avoid charges that policy is being made behind closed doors, it is important to give every group a chance to have their voice heard. Before public meetings, policymakers should be briefed on answers to difficult questions and arguments.

Task 4. Adopt the policy

✓ **Present the final draft** to the policymaking body along with useful background information—but keep the amount of reading material to a minimum. Get a well-known and respected person onto the agenda to make a persuasive case for the policy.

Encourage the policy's supporters to turn up at the meeting to show their support.

✓ **Provide support** upon request as the decision-making body commences the policy adoption process according to its established procedures.

Task 5. Administer the policy

✓ **Implement the policy.** Developing and adopting sound policies are only the first steps: implementing them requires good planning and management skills, the necessary resources, consistent enforcement, and widespread buy-in by staff and the public. Communication, dialogue, and public education are key.

Allow sufficient time for people to prepare for the implementation. Some

Compromise

The policy adoption process typically involves trade-offs and compromises. Sound policies must take into consideration factual knowledge about how specific needs can be best addressed but also need to take into account the interests of those who are affected by the policies, the complexity of the situation, the political climate, and the laws that limit schools' actions. Policymaking is always a juggling act of all these factors. The nature of policymaking is to strike a balance between competing interests. Expect that no one will be fully happy with the result.

Compromise should not be viewed as a defeat or a "sell out." Instead, it can be considered "a partial victory" that lays a good foundation for future efforts.

Tips for Successful Public Meetings

Board meetings and public hearings, whether at the state or local level, can sometimes become unruly as passions flow. Policymakers should review their public meeting rules and procedures to ensure they support a climate of rational, civil discourse. Rules should encourage expression of different perspectives on an issue, but not allow anyone to dominate the microphone. Some tips:

- Distribute written guidelines on procedures and expected behaviors so everyone in the audience knows the ground rules.
- Ensure that a good number of school health supporters and coalition members are present in the audience.
- Designate a fixed period of time for discussing a specified topic, which can extend over more than one meeting.
- Enforce strict time limits for those who want to make comments. Five minutes is typical.
- Immediately cut off the microphone if a speaker uses abusive language or profanity.
- Require that each person speaking state the school and grade their children attend.
- Require that people wanting to speak sign in first and then randomize the order of speakers to prevent pre-scripted relay presentations.
- Policymakers should resist pressures to make immediate decisions during a hearing. The purpose of a public hearing is generally to gather input, not to debate.
- Differences in opinion must be respected, but interruptions, personal insults, or indecorous language do not belong in public discourse and do not have to be tolerated.

—National Schools Boards Association[3]

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staff training may be necessary. Be vigilant but flexible as people adjust to the new policy.

✓ **Implement a proactive communications plan** to inform, educate, and build support for the policy among school staff, families and students, and the community (see the discussion on "Enlisting Public Support" later in this chapter). Stress the benefits of the new policy. Prepare fact sheets, talking points, and other written materials. Translate the policies into other languages as needed so that everyone can easily understand them. Schedule and conduct information sessions for the media and parent groups.

✓ **Maintain the effort** after the initial push for implementation. People's attention may gradually flag as compelling new issues arise. A sustained effort is necessary. Periodically note how well the policy is being managed and enforced. Bring lapses to the attention of the appropriate school officials. Note any unanticipated problems— and benefits— of the policy. Help to ensure that the evaluation and feedback processes that should have been built into the policy are working smoothly. Continue implementing public communications activities.

Resources

➢ Your state department of education or regional school district may be able to provide policymaking advice and sample policies.

➢ **The National Association of State Boards of Education** (NASBE) provides consultation and technical assistance to state education leaders on a full range of policy topics, including school health policies and programs. NASBE maintains a database of state policies and important research information. Call (703) 684-4000, e-mail boards@nasbe.org, or go to www.nasbe.org.

➢ **The National School Boards Association** (NSBA) provides consultation and technical assistance to school districts on school health policies and programs. NSBA offers a series of policy issue briefs on foundation policies and other school health issues and maintain a database that includes sample district policies and important research information. Call (703) 838-6722 or go to www.nsba.org/schoolhealth.

3. Who's Who in Education Policymaking

The education system in the United States is a highly diverse, highly decentralized enterprise. Determining precisely who has policymaking authority over specific issues and programs can be a challenge.

Private schools generally operate with a minimum of influence or control from government; the degree of oversight depends on the state. Some are affiliated with religious organizations, and others are nonsectarian. Volunteer boards of trustees who are prominent members of the community and/or alumni of the school typically set policies for individual schools or groups of schools.

In contrast, **public** school governance is much more complex. The public education system is a shared responsibility of local, state, and federal governments with multiple actors, agencies, and organizations— and numerous acronyms— at each level. Schools must operate under several layers of rules and regulations as well as meet the expectations of parents and others in the community. The result is a complicated structural and political web that can be confusing to negotiate.

Following is a "playbill" to help identify key public education policymakers (see Chart 1, "A Typical Public Education Governance Structure," on the following page).

At the state level

The governor and legislature: The governor proposes a state budget and new programs, but the legislature has the final word on all state policy, budgets, and distribution of state funds. In recent years activist governors and legislators of both parties have discovered that devoting attention to systemic educational reform can bring popularity and support. By commanding media attention these high-profile leaders can be valuable, constructive shapers of public opinion, and they can mobilize broad support for needed changes.

On the other hand, these officials understandably want to be able to demonstrate results during their brief terms of office in time for the next election. Some are therefore prone to simplistic, politically expedient "reforms" that sound good but might distract the public from the real, long-term issues in education and children's welfare. Rapid turnover in these political offices can also be a challenge to policy continuity.

Often it is the staff members in governor's offices, legislators' offices, and legislative committee offices who are most influential at shaping policy initiatives. School health program supporters should not be distressed if, on a visit to the state capitol, the only appointments they can get are with staff members. These might be precisely the people who can best advance school health goals.

The state board of education (SBE): Policy responsibility for elementary and secondary education lies with the SBE in most states, although its scope of authority varies widely. State boards typically adopt education goals and standards, set graduation requirements, establish teacher certification requirements, adopt textbooks, and develop assessment programs to ensure that school districts and schools perform at acceptable levels. The governor appoints the board members in about two-thirds of the states; the members are directly elected in the rest.

State boards set many policies related to school health. For example, they can require that all students be taught nutrition education or participate in daily physical education. State boards tend to approach policymaking with a long-term perspective; they commonly provide stable, bipartisan leadership for the education system; and they are often receptive to broad ideas about what's best for children and families.

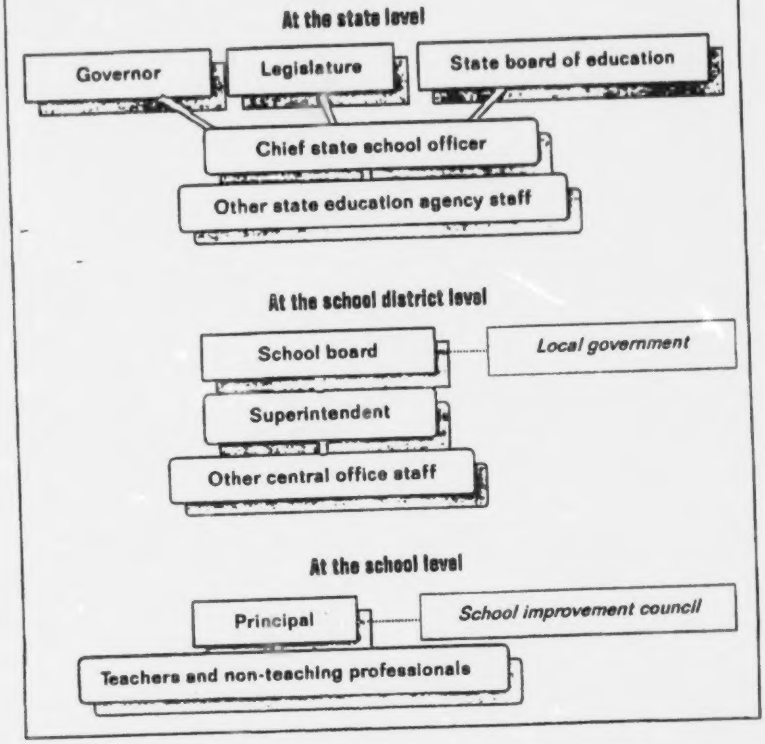
Most state boards are assigned an executive officer to handle administrative tasks; this person may also be closely involved with the policy development process.

The chief state school officer (CSSO, or "chief"): This official can go by several titles depending on the state: state superintendent, commissioner, secretary, or director of education. In any case, he or she functions as the chief executive officer over the state school system and is responsible for translating state policies from the legislature and/or state board of education into programs and regulations.

Typically, the chief is hired by the state board of education, but in one-third of the states the chief is independently elected, sometimes on a partisan basis. In some states the governor appoints the chief and he or she may sit in the governor's cabinet.

Chart 1

A Typical Public Education Governance Structure


At the state level
Governor
Legislature
State board of education
Chief state school officer
Other state education agency staff
At the school district level
School board
Local government
Superintendent
Other central office staff
At the school level
Principal
School improvement council
Teachers and non-teaching professionals

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The CSSO plays an important policymaking role by bringing timely issues to the attention of the state board and the legislature and by proposing draft policies for their consideration. The governor and legislature often consult the chief about possible legislative policies and programs.

The state education agency (SEA): Different states have various names for the SEA, but it most often referred to as the state department of education. Under the guidance of the CSSO, the career public servants who staff the SEA write and enforce regulations that govern many federal and state programs, distribute state and federal funds to local school districts, offer technical assistance and training, develop curricular and other guidelines, measure results, and otherwise implement state policies. Increasingly, they are participating in interagency initiatives that address the comprehensive needs of children and families.

Most SEAs employ specialists in health education, HIV and AIDS education, child nutrition, substance abuse education, and possibly health services. They generally are paid by and supported from federal categorical (i.e., program-specific) funds. Increasingly, SEAs are moving from a focus on enforcing state regulations to a focus on encouraging and assisting local change. Some SEAs have resources to build local capacity for school health programs, including staff who can provide training and technical assistance. SEAs can be particularly influential in rural districts that lack the resources to have their own specialists on staff.

Regional school districts: For efficient delivery of technical assistance and other services some states support "intermediate" or regional school districts, which go by different names. Health education and services units may be placed at this level.

At the school district level

The school board: More than 15,000 local school boards play a key role in governing public education in the United States. They make many of the day-to-day policies that are implemented by the local education agency and its schools. School boards were founded on the belief that local citizens should control the policies that determine how their children are educated. Most school board members nationwide are elected.

Every school board member wants to do what is best for children— but members can disagree about what that means. In addition to their personal views, school board members are strongly influenced by what they perceive to be the values and interests of their constituents. This can enable organized special interest groups to assert significant influence on board policies and programs. The diversity of constituencies sometimes makes it difficult for board members to reach a consensus on a common vision and strategy, particularly with regard to controversial health issues.

Local school board authority is not complete because education is constitutionally a state responsibility. Local districts are subject to state policies that may direct, limit, or otherwise influence local policymaking and implementation. Similarly, school boards that accept federal funds are required to adhere to federal policies and regulations.

School district boundaries do not always coincide with boundaries of other government jurisdictions. A school district may serve more than one municipality or county or sections thereof. Local school boards operate in many jurisdictions with full fiscal independence, often with their own taxing power. Some local school boards are required to work with the mayor, city council, or county supervisors where those bodies have budgetary authority. Relations among local school boards and city or county government can sometimes be strained.

The relative independence of local school districts from general government agencies and community power structures poses challenges for collaborative policymaking among school districts, health departments, child care and social service agencies, protective and juvenile services, and other agencies with responsibility for children's welfare. As a result there can be both overlap and neglect in provision of health and social services to children. In some localities, however, school districts and general government are engaging in collaborative policymaking across agencies and disciplines as a way to provide more efficient and effective services for children and families.

The district superintendent: The superintendent is the chief executive officer of the local school district and is responsible for implementing education policy. In most districts he or she is hired by the local school board.

There are a number of gray areas between a school board's policymaking authority and a superintendent's administrative responsibilities. The superintendent often drafts policy for the board to consider. Some boards become immersed in the day-to-day administration of their districts. These kinds of overlapping authority can result in tension between the superintendent and the school board.

Superintendents have administrative and support staff to assist in the development and implementation of policies and programs. The size of the superintendent's staff depends on the size and the resources of the district. Frequent budgetary crises in recent years have put pressure on local school boards and superintendents to reduce their central office staff in order to maintain fully staffed school buildings. A district may or may not have specialists or experts available to assist in drafting policies related to school health.

Unions and employee associations: Many school districts have active teachers' and administrators' unions. The National Education Association (NEA) has the most affiliates, although most teachers in large school districts are affiliated with the American Federation of Teachers (AFT). Unions represent front-line workers in education and can be key allies to those who want to advance school health goals.

At the school level

The principal: Each school has a principal who supervises the school's instructional program, maintains order and discipline, enforces state and district rules and policies, evaluates teachers, and represents the school to parents and the community. Some secondary schools have one or more assistant principals.

The principal can promote or undermine health-related policies. A principal with vision who exercises effective leadership can inspire and guide the entire school staff toward achieving health objectives. Conversely, a weak principal or one opposed to an expanded mission for schools can be a serious obstacle.

Other school staff: Increasingly, schools are being managed with significant input from other school staff who sit on "school improvement" or "site-based management" teams. In addition to teachers, these staff can include school nurses, school food service personnel, coaches, and janitors. Any of these staff can be enthusiastic supporters of school health policies and programs, or they can drag their feet and otherwise undermine health goals.

Parents, family members, and others in the school community: Because-most educators recognize the importance of parents, other family members, and members of the community in fostering student achievement, many schools actively encourage them to offer their opinions on school policies and programs as members of various advisory boards and school improvement committees. Where school-based management exists, family members may actually participate in school decision making through election or appointment to school governing bodies. Families tend to be enthusiastic and supportive about school health programs and are natural allies.

Charter schools

Charter schools are a kind of hybrid between public and private schools. Although they operate with public money and must conform to certain specified state requirements, health and safety standards, and federal civil rights laws, in most states they are granted considerable autonomy. Charter schools usually have their own governing bodies and great latitude to adopt their own policies, curriculum, and programs.

At the national level

The U.S. Department of Education: The federal government has only limited, narrow influence over education policy because public education is widely accepted to be primarily a state and local responsibility. The federal government provides only about seven percent of all education dollars nationwide. The U.S. Congress has mostly focused the federal role on three tasks:

1. enforcing civil rights laws that prohibit discrimination and ensure equity;
2. exercising policy leadership by sponsoring education research and pilot programs; and
3. providing partial funding to states and local school districts for educational programs targeted to economically disadvantaged children and children with special needs.

The primary involvement of the U.S. Department of Education in school health education and programs is via the Safe and Drug-Free Schools and Communities formula grant program. In recent years,

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federal program regulations have generally become more flexible allowing, for example, Title I funds to be used for some health and social services.

The U.S. Department of Health and Human Services (DHHS): Although DHHS has no direct policy authority over state or local education agencies, some grant funding for school health efforts comes from various agencies within DHHS. Most notably, the Centers for Disease Control and Prevention (CDC) provides funds for HIV/AIDS education to all state education agencies and some large cities and encourages states to support the widespread implementation of coordinated school health programs.

The U.S. Department of Agriculture (USDA): Schools can receive funding support and supplies for school food services through the National School Breakfast Program, the National School Lunch Program, and several other programs. Acceptance of program funds generally requires conformance with a related set of policies and regulations.

National associations: A large number of private, nonprofit membership associations address their dues-paying members' policymaking needs in various ways. Among other tasks, associations are generally charged with:

- representing their members' needs and interests at the national level;
- disseminating news, research findings, and other current information to members and the public at large; and
- providing state-of-the-art advice, assistance, and professional development to their members.

Some associations are organized according to profession (e.g., the National Association of School Nurses), others focus on the whole range of education policy issues (e.g., NASBE and NSBA), and some are organized to promote specific policy goals (e.g., the Campaign for Tobacco-Free Kids).

Private foundations: Some private foundations have provided leadership on school health policy issues through their grant-making activities and sponsorship of original research, including the Carnegie Corporation of New York and the Robert Wood Johnson Foundation. Many local and business-related foundations provide direct funding support for specific school health activities.

Resources

- *How Schools Work and How to Work with Schools* (2000) from the **National Association of State Boards of Education** (NASBE) is an orientation for health and social services professionals to the education system intended to facilitate interagency collaboration. Call (800) 220-5183 to order or go to www.nasbe.org for information.
- The book *Health Is Academic: Creating Coordinated School Health Programs* (1998) from the **Education Development Center** (EDC) contains detailed information on the roles of various people at different levels of government in developing and implementing school health programs. Contact Teachers College Press at (800) 575-6566.

4. Enlisting Public Support

Those who want to strengthen school health programs might have to conduct a well-organized effort to publicize the value of the programs and build support for new policies. Private sector marketing processes, principles, and techniques can be used to further social goals.

Developing a communications plan

A carefully crafted plan that identifies audiences, objectives, strategies, and tailored messages ought to guide all communications and activities. Key audiences might include some combination of students, parents, education policymakers, business leaders, and other influential people. At the state level, education policymakers and those who want to influence them need to pay special attention to the concerns of legislators, key executive branch staff, and business leaders.

The objectives of a public communications plan might include the following:

- increasing community *awareness* of the benefits, importance, and value of school health programs;
- generating *support* for school health programs; and/or
- increasing active community and business *involvement* in support of school health programs.

An effective communications program needs to be based on an understanding of the needs and perceptions of the audiences being targeted for attention. Where resources permit, public opinion research can help to clarify the public's priority concerns. Focus groups and other organized discussion forums are other ways to determine people's interests and worries.

Once a campaign's priority populations are selected and their perceptions are

Effective Messages

Recently, the National Association of State Boards of Education (NASBE) and the National School Boards Association (NSBA) jointly sponsored a series of telephone interviews and focus group discussions on how to build support for school health programs within the business community. The following message concepts tested well with business leaders and employees:

- **"Coordinated school health programs help children and young people make the right choices for leading healthy and productive lives. Young people are confronted with many pressures, such as AIDS, drugs, and violence. Therefore, it is very important that today's young people have the knowledge, skills, and resources to make the best decisions for their health and future."**
- **"Coordinated school health programs help young people grow into healthy and productive adults by giving them the resources they need to make healthful decisions in their lives. To ensure that our country's children become productive and successful members of our society and our workforce, we must give them the opportunity to be healthy children."**

—National Association of State Boards of Education[3]

understood, the next step is to develop brief and simple messages that will be persuasive. For example, a message for business leaders might be that health problems of school-age children affects the productivity of the current workforce when employees are called away from work to pick up sick children, need to take their children to doctor's appointments, or are preoccupied with a child's condition. It could be argued that school health programs help reduce employee absenteeism, increase productivity, and decrease levels of stress.

Looking toward the future workforce, business leaders might recognize that the best way to prevent substance abuse, smoking, poor nutrition, disease, and violence is through school health programs that foster the development of healthy behaviors during childhood and adolescence.

The most appropriate communications channels for gaining the attention of the priority audiences also need to be carefully determined. It is generally best not to rely on just one type of media. The more outlets that are used to promote a pro-school health message, the more people will be reached. Receiving the same message through multiple channels helps to reinforce it in people's minds.

Building coalitions

School health supporters are often most effective when they join together under a common umbrella. A school health coalition can have a higher public profile if it has a conspicuous identity— a name and logo with an easy-to-understand theme-- that is easily recognizable by the general public. This can provide consistency and continuity of communication in outreach efforts and materials. For example, the Healthier Schools Coordinating Committee in New Mexico chose the theme "Healthier schools are the heart of our community— put your heart into it."[2] Local design firms sometimes create logos and other promotional materials on a pro bono (free) basis in exchange for public acknowledgment.

Media relations

A valuable strategy to publicize and build support for school health policies is to cultivate effective working relationships with local media representatives. School

Tips for Working with Reporters

When dealing with reporters...

- **contact the appropriate reporter or editor for your story idea, perhaps suggesting a new angle to an old story;**
- **offer information that is valuable, accurate, fresh, and timely;**
- **tailor the story to the community, perhaps "localizing" a national policy initiative;**
- **involve a public figure;**
- **use pictures and human interest stories;**
- **respond quickly to requests for additional information or interviews; and**
- **be prepared to answer questions and discuss issues in depth.**

On the other hand, do not...

- **offer old news that has already been covered;**
- **call when they are on deadline; or**
- **persist if a story idea is rejected.**

—National Association of State Boards of Eudcation[3]

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officials can invite reporters, talk show hosts, and television news producers to demonstrations of exemplary school initiatives, news conferences, and key public hearings. Print, video, or audiotape interviews and submitted guest commentaries help to inform the public. Proactive school officials find the time to brief— and educate— media representatives about important school issues and related state, district, and school policies.

Resources

- *Building Support for School Health Programs: An Action Guide* (1999) from the **National Association of State Boards of Education** (NASBE) provides detailed, step-by-step guidance on how to encourage state and local businesses to support school health efforts. Call (800) 220-5183 or go to www.nasbe.org for information.
- The **National School Public Relations Association** (NSPRA) can offer assistance and advice on communications planning. Call (703) 528-5840.
- The **Education Commission of the States** (ECS) offers *Building Community Support for Schools: A Practical Guide to Strategic Communications* (1997). Call (303) 299-3692.
- *How to Deal with Community Criticism of School Change* is available from the **Association for Supervision and Curriculum Development** (ASCD) at (703) 549-9110.

References

[1] National School Boards Association, *Becoming a Better Board Member: A Guide to Effective Board Service*, 2nd ed., 1996, p. 61–62.

[2] National Association of State Boards of Education, *Someone at School has AIDS: A Complete Guide to Developing Education Policies Concerning HIV Infection*, 1996, p. 2.

[3] National Association of State Boards of Education, *Building Business Support for School Health Programs: An Action Guide*, 1999.

[4] National Association of State Boards of Education, "Characteristics of Good Policy Research," *NASBE Boardsmanship Review*, January 1998.

[5] Stover, D., "School boards seek to restore civility to unruly meetings," *School Board News*, National School Boards Association, February 10, 1998.

C. General School Health Policies

Young people are more likely to adopt health-enhancing behaviors if they receive consistent messages that support a healthy lifestyle from many different sources. Schools can play an essential role in communicating the healthy lifestyle message through coordinated policies and programs and the interactions between staff and students. Linking school health promotion efforts to the family and the community further reinforces the message. Schools can— and invariably do— play a powerful role in influencing students' health-related behaviors.

This chapter establishes an "umbrella" school health policy— an overall policy framework to which additional policies that address priority health topics can be appended. Later chapters address policy issues specific to physical activity, healthy eating, and tobacco-use prevention.

Fulfilling the Promise of Education Reform

Redesigning school systems to meet the comprehensive needs of children helps education reform fulfill its promise.... Attention to children's health is not optional. Beyond the delivery of actual services, often coordinated through other agencies, schools must rethink the role of curriculum, instructional strategies, school environment, student and personnel policies, and all aspects of school life to foster healthy children who are ready to learn every day.

—BellSouth Foundation and Education Development Center[1]

A complete school health policy will:

- promote health in multiple ways;
- emphasize the value of coordinating all components of the school that deal with health issues; and
- address the needs of staff as well as students.

The sample policies in this guide are intended as statements of recommended practice. What is reasonable, feasible, and acceptable in a given state, school district, or school depends on local circumstances and the results of the policymaking process.

The sample general school health policy is divided into five parts, as listed below in the chapter table of contents. Each part of the policy is followed by a discussion section that provides supportive information, plus a concise list of key resources.

Chapter contents

1. A Vision for School Health C-3

2. The Coordinated School Health Program C-9

3. Administration and Evaluation.................................. C-23

4. Health Education C-33

5. Well-Prepared Staff.. C-41

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1. A Vision for School Health

A strong vision statement expresses the philosophy and assumptions of governing policymakers. It justifies the policy to staff and the public, communicates policymakers' priorities, orients the policy development process, and helps guide program implementation. A vision statement can help persuade people who do not understand the need for the policy to lend their support to school health program goals.

A vision statement can be communicated in a number of ways. It might be in the form of a resolution if it is not enshrined in a formal policy or regulation.

General School Health Sample Policy, Part One:

INTENT. Families are the primary teachers and caregivers for their children. The present and future health, safety, and well-being of students are also the concern of state/district/school. Schools have a duty to help prevent unnecessary injury, disease, and chronic health conditions that can lead to disability or early death. For students to learn to take responsibility for their own health and to adopt health-enhancing attitudes and behaviors:

- every school shall be a safe and healthy place for children and employees to learn and work, with a climate that nurtures learning, achievement, and growth of character;
- all students shall be taught the essential knowledge and skills they need to become "health literate"—that is, to make health-enhancing choices and avoid behaviors that can damage their health and well-being;
- each school shall be organized to reinforce students' adoption of health-enhancing behaviors, and school staff shall be encouraged to model healthy lifestyles; and
- school leaders shall ensure that the nutrition, health services, and social services children need in order to learn are provided either at the school site or in cooperation with other community agencies.

RATIONALE. Health and success in school are interrelated. Schools cannot achieve their primary mission of education if students and staff are not healthy and fit physically, mentally, and socially. Credible surveys indicate that alarming proportions of young people engage in behaviors that put them at risk of serious health problems. In addition, the nation's leading health authorities recommend that schools take an active role in preventing disabling chronic health conditions that create misery and consume a burdensome share of the nation's resources.

Discussion

High-quality, well-coordinated school health programs can be justified on the basis of short-term benefits for student learning and on the basis of long-term benefits for public health. In the short-term, studies of young people have found that health-risk behaviors negatively affect:

- *education outcomes*, including graduation rates, class grades, and performance on standardized tests;
- *education behaviors*, including attendance, dropout rates, behavioral problems and degree of involvement in school activities such as homework and extracurricular pursuits; and
- *student attitudes*, including aspirations for postsecondary education, feelings about safety at school, and positive personal attitudes.[2]

A Healthy School

A healthy school is one that integrates community, family, and schools to provide for students a positive continuum of intellectual, physical, social, and emotional development on which to base lifelong decisions.

—NASBE Healthy Schools Network[3]

It is not difficult to understand that a hungry, ill, substance-abusing, or emotionally distressed child cannot achieve to high academic standards. One child's lack of progress impedes the learning of the other children in the classroom as well. Education reform efforts now being undertaken throughout the country are bound to be of limited effectiveness unless health-related barriers to learning are directly addressed.

Regarding the long-term benefits for the future health of students and their families, the Centers for Disease Control and Prevention (CDC) has concluded that:

> The health of young people—and the adults they will become—is critically linked to the health-related behaviors they choose to adopt. A limited number of behaviors contribute markedly to today's major killers. These behaviors, often established during youth, include:
>
> - tobacco use;
> - unhealthy dietary behaviors;
> - inadequate physical activity;
> - alcohol and other drug use;
> - sexual behaviors that may result in HIV infection, other sexually transmitted diseases, and unintended pregnancies; and
> - behaviors that may result in intentional injuries (i.e., violence and suicide) and unintentional injuries (e.g., motor vehicle crashes).
>
> Among both children and adults, the leading causes of death are closely linked to these behaviors. Among adults, chronic diseases—such as cardiovascular disease, cancer, and diabetes—are the nation's leading killers. Practicing healthy behaviors, such as eating low-fat, high-fruit-and-vegetable diets, getting regular physical activity, and refraining from tobacco use, could prevent many of these deaths. Because health-related behaviors are usually established in childhood, positive choices need to be promoted before damaging behaviors are initiated or become ingrained.[4]

Unfortunately, credible surveys find that large numbers of students are engaging in behaviors that can harm their health and their performance at school (see box, "Some Alarming Statistics").

When surveyed, parents consistently rate health as an important topic that schools should address. Although the primary mission of schools is education, schools should also accept a *share* of the responsibility for the physical, mental, and social well-being of children and

Some Alarming Statistics

Results from the 1997 Youth Risk Behavior Survey of students in grades nine through twelve, indicate that many young people practice health-risk behaviors that can jeopardize their future:

- Nationwide, only 29.3 percent of high school students had eaten the recommended five or more servings of fruits and vegetables during the day before the survey. More than one-third (37.7 percent) had eaten more than two servings of foods typically high in fat content such as hamburgers, hot dogs, french fries, potato chips, and sweets.
- Three-fifths (59.7 percent) of female high school students, and 23.1 percent of male students, said they were trying to lose weight. In fact, 7.5 percent of young females reported they had taken laxatives or vomited to lose weight or keep from gaining weight, and 8.0 percent said they had taken diet pills in the past 30 days.
- Nearly half (46.5 percent) of female students, and more than one-fourth (27.7 percent) of male students, had not participated in vigorous physical activity (activities that made them sweat and breathe hard) for at least 20 minutes on three or more of the seven days before the survey, which is the minimum amount recommended by the nation's health authorities.
- More than one-third (36.4 percent) of high school students were current smokers. One-fourth (24.8 percent) had smoked a whole cigarette before age 13.
- One-fifth (20.6 percent) of white male students were current users of spit (smokeless) tobacco.
- During the 30 days before the survey, more than one-third (36.6 percent) of students had ridden with a driver who had been drinking alcohol, and 16.9 percent had driven a vehicle after drinking.
- Half (50.8 percent) of all students were currently using alcohol—that is, they had had at least one drink in the past 30 days. One-third (33.4 percent) had had five or more drinks at one sitting.
- Sixteen percent of all students had sniffed glue, breathed the contents of aerosol spray cans, or inhaled paint sprays to become intoxicated.
- More than one-fourth (27.7 percent) of male high school students had carried a weapon (e.g., a gun, knife, or club) in the past 30 days, and 12.5 percent had carried a weapon on school property.
- Nearly half (45.5 percent) of male students had been in a physical fight during the preceding 12 months.
- More than one-fourth (27.1 percent) of female high school students and 15.1 percent of male students had seriously considered attempting suicide in the preceding 12 months.
- Nearly half (48.4 percent) of all high school students had had sexual intercourse at least once in their lifetime, and 16.0 percent had had four or more sex partners. Among black male students, 80.3 percent had had sex, and more than half (52.8 percent) had had four or more partners.

—Centers for Disease Control and Prevention[3]

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adolescents. For many young people, school may be the only place where they learn health information and have positive behavior consistently reinforced.

Inextricably Linked

The health and the education of our children are inextricably linked. Children who are sick, hungry, abused, or using drugs, feeling that nobody cares, and who may be distracted by family problems are unlikely to learn well. Schools are also places where foundations for future health behaviors are laid. The promotion of good health for children and youth in the school setting is a shared responsibility of families, schools, and communities.

—Joint Statement of the New Mexico
Secretary of Health and the New Mexico
State Superintendent of Public Instruction[5]

An Attainable Vision

The vision of a comprehensive [i.e., coordinated] school health program (CSHP) in each of our nation's schools at first may seem daunting and out of reach, but a closer look suggests that this vision is in fact not so far from reality. Many parts of the infrastructure needed to support CSHPs—the basic underlying framework of policies, financial and human resources, organizational structures, and communication channels that will be needed for programs to become established and grow—already exist or are emerging.

—Institute of Medicine[8]

Health and Education Joined

Health and education are joined in fundamental ways with each other and with the destinies of the nation's children. Good health facilitates children's growth, development, and optimal learning while education contributes to children's knowledge about being healthy.

—Joint Statement of the Vermont
Secretary of Human Services and the
Vermont Commissioner of Education[6]

Lowering the Barriers to Learning

Many who labor in the arena of public policy are facing the reality that 15 years of energetic school reform efforts have produced some modest improvements, but not the hoped-for results. Merely setting standards, using better tests, telling teachers to teach better, tightening certification requirements, or getting rid of principals or superintendents when test scores don't rise hasn't brought us to the promised land—or even the edge of it. Many people now question the current orthodoxy that only academic outputs matter and that any discussion of inputs is a delaying tactic on the part of the educators.

While there are no signs of any political retreat from the steely focus on academic outcomes, there is an awakening to the notion that education reform may require creative interventions that lower the barriers to learning and reduce risky behavior. First among those barriers are poor physical and mental health conditions that prevent students from showing up for school, paying attention in class, restraining their anger, quieting their self-destructive impulses, and refraining from dropping out.

—Harriet Tyson[7]

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Resources

- *The Future Is Now: Addressing Social Issues in Schools of the 21st Century* (1999), the report of the **NASBE Study Group on Confronting Social Issues: The Role of Schools**, presents a strong case that schools need to address students' health concerns. To order call (800) 220-5183.
- *Trends in the Well-Being of America's Children and Youth* is an annual report from the **U.S. Department of Health and Human Services** that presents the most recent and reliable estimates on more than 80 indicators of well-being. Go to http://aspe.os.dhhs.gov/hsp/hspyoung.htm.
- Information about CDC's **Youth Risk Behavior Surveillance System** is available by calling (770) 488-3168 or visiting www.cdc.gov/nccdphp/dash/yrbs.
- The **National Center for Education Statistics** of the U.S. Department of Education annually produces the compendium *Digest of Education Statistics*. Call (877) 4-ED-PUBS or visit http://nces.ed.gov.
- The **Federal Interagency Forum on Child and Family Statistics** annually produces *America's Children: Key National Indicators of Well-Being*. It can be ordered through the National Maternal Child Health Clearinghouse at (703) 356-1964 and is available online at http://childstats.gov.
- KIDS COUNT, a project of the **Annie E. Casey Foundation**, is a national and state-by-state effort to track the status of children in the United States. Reports are issued annually, and a powerful online database allows users to generate custom graphs, maps, ranked lists, and state profiles. Call (410) 547-6600 or go to www.aecf.org.
- The YouthInfo website of the **U.S. Department of Health and Human Services** provides the latest information about America's adolescents, including statistics, reports, and resources for parents. Go to http://youth.os.dhhs.gov.
- *Reducing the Risk: Connections That Make a Difference in the Lives of Youth* is a report of the **National Longitudinal Study of Adolescent Health** (Add Health). This school-based study of the health-related behaviors of adolescents in grades 7–12 is designed to explore the causes of these behaviors with an emphasis on the influence of social context. Go to www.cpc.unc.edu/addhealth/home.html.

2. The Coordinated School Health Program

A school health program policy that encompasses all eight of the individual components of the coordinated school health program model can enhance the program's effectiveness by helping school health staff ensure that their activities are mutually reinforcing. A complete policy also helps to identify gaps in programs and services.

General School Health Sample Policy, Part Two:

COORDINATED SCHOOL HEALTH PROGRAM. Every school district and school shall develop, adopt, and implement a comprehensive plan for a thorough, well-coordinated school health program that shall:

- be designed in response to demonstrated needs in the community;
- be based on models that demonstrate evidence of effectiveness;
- emphasize a positive youth development approach;
- make efficient use of school and community resources; and
- respond to families' needs and preferences.

The coordinated school health program plan shall incorporate the following eight components within a single framework:

1. a **school environment** that is safe; that is physically, socially, and psychologically healthful; and that promotes health-enhancing behaviors;
2. a sequential **health education curriculum** taught daily in every grade, pre-kindergarten through twelfth, that is designed to motivate and help students maintain and improve their health, prevent disease, and avoid health-related risk behaviors and that is taught by well-prepared and well-supported teachers;
3. a sequential **physical education curriculum** taught daily in every grade, pre-kindergarten through twelfth, that involves moderate to vigorous physical activity; that teaches knowledge, motor skills, and positive attitudes; that promotes activities and sports that all students enjoy and can pursue throughout their lives; that is taught by well-prepared and well-supported staff; and that is coordinated with the comprehensive school health education curriculum;

4. a **nutrition services program** that includes a food service program that employs well-prepared staff who efficiently serve appealing choices of nutritious foods; a sequential program of nutrition instruction that is integrated within the comprehensive school health education curriculum and coordinated with the food service program; and a school environment that encourages students to make healthy food choices;
5. a school **health services program** that is designed to ensure access or referral to primary health care services; foster appropriate use of health care services; prevent and control communicable disease and other health problems; provide emergency care for illness or injury; and is provided by well-qualified and well-supported health professionals;
6. a **counseling, psychological, and social services program** that is designed to ensure access or referral to assessments, interventions, and other services for students' mental, emotional, and social health and whose services are provided by well-qualified and well-supported professionals;
7. integrated **family and community involvement activities** that are designed to engage families as active participants in their children's education; that support the ability of families to support children's school achievement; and that encourage collaboration with community resources and services to respond more effectively to the health-related needs of students; and
8. a **staff health promotion program** that provides opportunities for school staff to improve their health status through activities such as health assessments, health education, and health-related fitness activities.

EFFECTIVE DATE. All *districts/schools* shall present a plan for a coordinated school health program to *whom* by *date*. The program shall be operational by *date*.

Discussion

The CDC along with many national organizations and membership associations promotes an eight-component school health program model that communities can shape to fit their circumstances.[10] The eight components, when planned and implemented well, are mutually reinforcing. A good program draws on the thoughts and efforts of many disciplines, community groups, and agencies and uses an inclusive and broadly based planning process. It is called the "coordinated school health program," with emphasis on the word *coordinated*.

A majority of school districts and schools already have most of the components in place in some form. Yet all too often these

School Health Program Defined

A comprehensive [i.e., coordinated] school health program is an integrated set of planned, sequential, school-affiliated strategies, activities, and services designed to promote the optimal physical, emotional, social, and educational development of students. The program involves and is supportive of families and is determined by the local community, based on community needs, resources, standards, and requirements. It is coordinated by a multi-disciplinary team and accountable to the community for program quality and effectiveness.

There is no single "best" comprehensive school health program model that will work in every community. Programs must be designed locally, and collaboration among all stakeholders in the community is essential if programs are to be accepted and effective.

—Institute of Medicine[8]

programs operate independently of one another or are forced to compete with each other for scarce resources. Some of the components might be missing or undeveloped, such as taking a systematic approach toward ensuring a healthful school environment or providing health promotion activities for staff.

School health programs support education reform

Some elements of school health programs parallel mainstream recommendations for general education reform. For example:

- health education fosters the kinds of "critical thinking skills" that employers want schools to teach;
- some "whole school reform" packages that demonstrate evidence of improved academic performance emphasize a psychologically supportive school climate;[8]
- hands-on, "active-learning" teaching methods parallel long-standing practice in health education; and
- most education reform initiatives highlight family and community involvement as critical to school success.

Many policymakers involved with education reform also explicitly look toward the business community for applicable lessons: one is that staff health promotion programs can significantly improve morale and productivity and are usually well worth the cost.[11]

The youth development approach

Policymakers can encourage schools to develop a full range of "life competencies" among students— not only academic and vocational competencies but also healthful living skills, personal and social skills, ethics, and citizenship.[12] Many states and districts are coming to recognize that a positive "youth development" philosophy can usefully inform a coordinated school health program (see box, "Restructuring Schools for Positive Youth Development," on the following page).

The youth development approach involves paying attention to students' strengths, not just their shortcomings; seeing them as valued members of the community instead of problems in need of correction; and setting goals that young people be "fully prepared" rather than "trouble-free." Catalano, Hawkins, and their colleagues have concluded that, "Promotion and

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Restructuring Schools for Positive Youth Development

In recent decades the Carnegie Corporation of New York has done much to strengthen the knowledge base in child and adolescent development. Six basic concepts underlie their recommendations for restructured schools to promote a "cohesive developmental strategy":

1. Education and health are inextricably related. Good health facilitates learning, while poor health hinders it, each with lifelong effects. Commensurately, a positive educational experience promotes the formation of good health habits, while academic failure discourages it.
2. The years 10–14 are a crucial turning point in life's trajectory. This period, therefore, represents an optimal time for interventions to foster effective education, prevent destructive behavior, and promote enduring health practices.
3. Destructive, or health-damaging, behaviors in adolescence tend to occur together, as do positive, health-promoting, behaviors.
4. Many problem behaviors in adolescence have common antecedents in childhood experience. One is academic difficulty; another is the absence of strong and sustained guidance from caring adults.
5. Preventive interventions are more likely to be successful if they address underlying factors that contribute to problem behaviors.
6. Given the complex influences on adolescents, the essential requirements for ensuring healthy development must be met through the joint efforts of a set of pivotal institutions that powerfully shape adolescents' experiences. These pivotal institutions must begin with the family and include schools, health care institutions, a wide array of neighborhood and community organizations, and the mass media.

—Carnegie Corporation of New York[14]

prevention programs that address positive youth development constructs are definitely making a difference in well-evaluated studies."[13]

The eight components

Following is further discussion of the eight components of the coordinated school health program model.

1. Healthy school environment

A healthy school environment encompasses physical issues such as safety hazards, air quality, water quality, sanitation, heating, ventilation, lighting, and access for persons with disabling conditions.

Another critical, but sometimes overlooked, aspect of a healthy environment is the social and psychological climate. Schools need to be places where all students and staff feel cared for, supported, included, safe, and personally valued.

To a large degree, a healthy psychosocial environment is a matter of enlightened leadership, good management, and thoughtful planning. For example, a large body of research in the affective and social realms overwhelmingly affirms the superiority of schools with small enrollments.[15] More attention is also being paid to the damaging effects of bullying and harassment on students' health and well-being.[16]

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Broad and Flexible

The coordinated school health program model is broad and flexible enough to incorporate many types of school improvement initiatives. An overall school health framework could integrate the following topics, among others:

- **substance use prevention;**
- **school safety and violence prevention;**
- **youth development initiatives;**
- **character education;**
- **drop-out prevention;**
- **services for students with disabling conditions;**
- **service learning; and**
- **before- and after-school programs.**

2. Health education

Health education should address the physical, mental, emotional, and social dimensions of health. A quality curriculum allows students to develop and demonstrate increasingly sophisticated health-related knowledge, attitudes, skills, and practices. A comprehensive curriculum includes a variety of topics, such as personal health, family health, community health, consumer health, environmental health, sexuality education, mental and emotional health, injury prevention and safety, nutrition, prevention and control of disease, and substance use and abuse.

3. Physical education

Quality physical education should promote, through a variety of planned physical activities, each student's optimum physical, mental, emotional, and social development. Physical education should provide cognitive content and learning experiences in a variety of activity areas, such as basic movement skills; physical fitness; rhythms and dance; games; team, dual, and individual sports; tumbling and gymnastics; and aquatics.

4. Nutrition services

Nutrition services should provide access to a variety of nutritious and appealing meals that accommodate the health and nutrition needs of all students. School nutrition programs should reflect the Dietary Guidelines for Americans and other criteria to achieve nutrition integrity. The school nutrition services program should also offer students a learning laboratory for classroom nutrition and health education and should serve as a resource for linkages with nutrition-related community services.

5. Health services

Schools have long provided some types of basic health services. As recommended by the American Academy of Pediatrics, every school should:

- ensure access to primary health care;
- provide a system for dealing with medical crises;
- provide mandated screening and immunization monitoring; and
- provide systems to identify and solve students' health and educational problems.[17]

Although only 53 percent of states required schools to offer school nurse services in 1994,[18] nearly every school had provisions for administering first aid (99 percent), administering medications (97 percent), and conducting vision, hearing, and height/

School Health Services Policy Issues

It is beyond the scope of this guide to go into detail about the many issues pertaining to school health services: see the resources list at the end of this section for specialized sources of assistance. Some of the key issues policymakers should pay attention to include the following:

- rules about administering and storing medications;
- required immunizations and school attendance;
- health screening requirements;
- reporting, record-keeping, and confidentiality requirements;
- requirements for infection control ("universal precautions") procedures;
- student-to-school-nurse ratios;
- health personnel licensing and certification systems;
- issues pertaining to students or staff with HIV infection;
- administrative and technical support for school health services by states and districts;
- state grant programs for school-based and/or school-linked health services; and
- operating standards for school-based health services to foster quality of care and effectiveness.

Services Provided in School-Based Health Centers

In contrast to some people's image of what services students seek, national surveys suggest that reproductive health care prompts only 15 percent of student visits to school-based centers. The other 85 percent of visits illustrate how comprehensive the services are:

- The largest number of visits—32 percent of the total in 1992-93—is for treatment of acute illnesses and injuries.
- Preventive health visits, including physical exams, health education, and guidance, account for 22 percent of services.
- One in five visits is related to mental health.
- Finally, chronic disease management accounts for seven percent of visits.

—Robert Wood Johnson Foundation[19]

weight screenings (89 percent).[20] However, fewer schools provided less traditional services, such as mental health counseling (56 percent) or conducting health-risk appraisals to help students determine their lifestyle practices (36 percent).

In recent years schools have been establishing school-based or school-linked health centers, many of which offer a wide range of physical and mental health services (see box, "Services Provided in School-Based Health Centers"). A national survey identified a total of 1,157 school-based health centers that provided in-school care to children during the 1997–98 school year.[21] Thirty-seven percent were housed in high schools, 16 percent were in middle schools, 34 percent were in elementary schools, and the remainder were off-site. Most were concentrated in urban centers but increasing numbers are being established in rural areas. Many are able to

Barriers to Learning

- *Inadequate basic resources* such as food, clothing, housing, and a sense of security at home, school, and in the neighborhood.
- *Psychosocial problems* such as difficult relationships at home and at school; emotional upset; language problems; sexual, emotional, or physical abuse; substance abuse; delinquent or gang-related behavior; and psychopathology.
- *Stressful situations* such as being unable to meet the demands made at school or at home, inadequate support systems, and hostile conditions at school or in the neighborhood.
- *Crises and emergencies* such as the death of a classmate or relative, a shooting at school, or natural disasters such as earthquakes, floods, or tornadoes.
- *Life transitions* such as the onset of puberty, entering a new school, and changes in life circumstances (moving, immigration, loss of a parent through divorce or death).

—Howard Adelman[23]

bill Medicaid and private health insurance firms for services rendered to students who are covered.

6. Counseling, psychological, and social services

In a 1999 report on mental health, the Surgeon General cited estimates that 21 percent of U.S. children ages 9–17 have a diagnosable mental or addictive disorder.[22] Yet studies indicate that approximately 70 percent of children and adolescents in need of treatment do not receive mental health services.[22] Schools cannot overlook such "barriers to learning" (see box) if students are to achieve to high academic standards.

Of those young people who do receive mental health services, about 70 percent receive services from schools compared to 40 percent using mental health specialists and 11 percent using the health sector (the numbers overlap because a young person might access more than one resource). The

School Counseling, Psychological, and Social Services Policy Issues

Among the issues education policymakers should address are the following:

- establishing a cohesive vision for nonfragmented programs that address barriers to student learning and healthy development of youth;
- establishing a continuum of services ranging from primary prevention to early intervention to treatment for severe problems in a range of school and community settings;
- blending categorical program funds to serve students in need in a flexible manner;
- reporting, record-keeping, and confidentiality requirements;
- specifying required ratios of pupil services professionals to students, e.g., 1:200–250;
- maintaining state-of-the-art licensing and certification requirements for pupil services professionals; and
- determining the types of administrative and technical support to be provided by states and districts.

Key Findings from the "Add Health" Study

Time and time again, the home environment emerges as central in shaping health outcomes for American youth.... Children who report feeling connected to a parent are protected against many different kinds of health risks, including: emotional distress and suicidal thoughts and attempts; cigarette, alcohol, and marijuana use; violent behavior; and early sexual activity. When a parent is physically present in the home at key times, and has high expectations for the child's education, children are on the road to being protected from involvement in behaviors that can damage them.

—National Longitudinal Study of Adolescent Health ("Add Health")[24]

Surgeon General's report notes that "schools are the primary providers of mental health services for children" and "offering services in the schools improves treatment access."[22]

The report also acknowledges that private and public health insurance coverage for such services is often lacking. Schools can make efforts to enter into collaborative relationships with other service providers for help with the resource burden.

7. Family and community involvement

Parents and family members are children's first and most influential teachers (see box, "Key Findings from the 'Add Health' Study"). An extensive literature links parent involvement to their children's achievement, academic standing, and grade repetition.[25] School health programs should be designed to assist and support families to effectively teach healthy habits and behaviors. A number of studies have shown that involving parents enhances the effects of school health promotion efforts.[26]

The National Center for Education Statistics cites research showing that certain school practices that involve families are strong predictors of parent involvement.[25] For example, parents' reports of schools' communication with them about school programs and activities, and schools' efforts to help parents help their children learn at home, have been related to overall levels of parent involvement.

The National Parent Teachers Association (National PTA) has developed national standards for parent/family involvement programs (listed below). The six standards

National Standards for Parent/Family Involvement Programs

Standard I: *Communicating*—Communication between home and school is regular, two-way, and meaningful.

Standard II: *Parenting*—Parenting skills are promoted and supported.

Standard III: *Student Learning*—Parents play an integral role in assisting student learning.

Standard IV: *Volunteering*—Parents are welcome in the school, and their support and assistance are sought.

Standard V: *School Decision Making and Advocacy*—Parents are full partners in the decisions that affect children and families.

Standard VI: *Collaborating with Community*—Community resources are used to strengthen schools, families, and student learning.

—National PTA[27]

and their quality indicators provide PTAs, schools, and communities with voluntary guidelines for highly effective parent/family involvement programs.

> **Open Our Doors**
>
> **What schools need to do is simple: open our doors. We can ensure that students are getting the services they need by cooperating with agencies whose missions are health or social services.**
>
> **—Dorothy Beardmore, President, Michigan State Board of Education[28]**

Schools are increasingly open to the concept of close collaboration with services in the community. State and local government agencies, private businesses, youth-serving organizations, and other organizations in the community can be valuable additions to school health programs by:

- serving as resources for student learning;
- offering opportunities for student service;
- coordinating community health-promotion efforts with school programs so as to be mutually reinforcing;
- raising funds to support specific activities; and
- providing expert advice and assistance to school health program planners.

The "full-service school" model involves locating a variety of family and youth services at school to improve families' access to the services. Independent researcher Joy G. Dryfoos offers a vision for schools that provide adolescents with a safe passage to adulthood (see box, "Vision of a 'Safe Passage School'"). New Jersey and Kentucky have pioneered statewide programs of linking schools with community agencies (see box, "Kentucky's Family Resource and Youth Services

Vision of a "Safe Passage School"

Quality education provided by the school system	*Provided by either*	*Support services provided by community agencies*
Basic academic skills	Comprehensive school health education	Health, mental health, and dental services
Individualized instruction	Health promotion	Family planning
Team teaching	Preparation for work	Individual counseling
Cooperative learning	Social work	Family services (basic needs such as housing, food, clothing)
Site-based management	Psychological services	Welfare services, case management
Healthy school climate		Recreation, sports, and culture
Alternatives to tracking		Mentoring and tutoring
Effective discipline		Parent education, literacy
		Childcare before and after school
		Employment training and job placement
		Community policing
		Community gardening

—Joy Dryfoos[29]

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Kentucky's Family Resource and Youth Services Centers

[Family Resource/Youth Services Centers are intended] to assist in the removal of social, economic, and health barriers to student success by coordinating services available through existing community agencies and providing additional services when necessary.

Centers serve students in schools where 20 percent or more of the students are eligible for the federal lunch program.

Communities and schools form partnerships to design programs to meet the needs of the students and families served by the Center.

Family Resource Centers serve elementary schools, providing access to childcare, after-school child day care, parenting training, child development training, parent and child education, and health screening services and referrals.

Youth Services Centers serve middle and secondary schools, providing access to health and social services, including: employment counseling, training and placement, summer and part-time job development, drug and alcohol abuse counseling, and family crisis and mental health counseling.

The Interagency Task Force on Family Resource/Youth Services Centers, in conjunction with the Cabinet for Families and Children, provides administration and oversight, technical assistance, and training.

—Kentucky Department of Education[30]

Centers"). Providing these kinds of services does not necessarily require an increase in the school's budget: typically, many of these services already exist but in a fragmented manner that some families find difficult to use. The Institute of Medicine concludes that,

> Comprehensive school-affiliated family services are increasingly considered to be an important means for reaching families and for improving academic, health, and social outcomes for students.[8]

8. Staff health promotion

Organized programs of staff health promotion are perhaps not as familiar to many policymakers as other components of the coordinated school health program. Yet in recent years these programs have proven their financial value in both the business and public sectors (see box, "Wellness Makes a Bottom-Line Difference," on the following page). Another benefit of these programs is that school staff who practice healthy lifestyles are good role models for students.

School-site health promotion activities for staff are designed to promote the physical, emotional, and mental health of school employees as well as to prevent disease and disability. In addition to saving on health care costs, some health-conscious school districts see wellness programs as a way to spur recruitment, improve daily attendance, earn the loyalty of their workers, and promote employees' general health and well-being.

A staff health promotion program might include some or all of the following elements:

- education about good nutrition and weight management;
- supportive activities to reduce health-risk factors, such as offering smoking-

cessation courses and nicotine-replacement aids, making ergonomic improvements, providing discounts at fitness clubs, teaching about prevention of back injuries, creating on-site exercise areas, or screening for health-risks such as cholesterol, high blood pressure, and cancer risk factors;

- organizational policies that promote a healthful and psychologically supportive work environment;
- integrated employee assistance programs for those experiencing psychological and social problems; and
- employee health care, including health insurance and access to school health services.

Wellness Makes a Bottom-Line Difference

Today, more than 81 percent of America's businesses with 50 or more employees have some form of health promotion program—the most popular being exercise, stop-smoking classes, back care programs, and stress management.... Worksite wellness is health care reform that works:

- A medical claims-based study of 72,000 people insured through 285 Wisconsin school districts found a lower demand for medical services among those with access to disease prevention and self-care programs. Reductions in medical services results in savings for the Wisconsin Education Insurance Group of as much as $4.75 for each $1.00 spent—higher savings were found in the group receiving access to a 24-hour phone-based nurse advice line, a self-care reference book, and health education materials.
- With lower health care claims, medical costs decreased 16 percent for the employees in the City of Mesa (Arizona) who participated in the comprehensive health promotion program. The city realized a return of $3.60 for every dollar invested in the health of city employees.
- The Stay Alive & Well program at Reynolds Electrical & Engineering Company, based in Las Vegas, cost $76.24 per employee during the two years it has been in operation. Over half of the 1,600 employees participated (with up to 80 percent participation rates in the intervention program). Participants significantly lowered cholesterol levels, blood pressure, and weight and experienced 21 percent lower lifestyle-related claim costs than non-participants. Resulting savings: $127.89 per participant with a benefit-to-cost ratio of 1.68 to 1.

—Wellness Councils of America and Canada[11]

Resources

- Every state department of education has staff who work on school health issues (their titles and office names vary from state to state). Contact them for regulatory guidance, advice, and materials.
- The **Vermont State Department of Education** distributes a useful checklist entitled "Healthy Schools—Critical Questions" as part of its *Vermont Comprehensive School Health Program Guidelines* (1996). Schools can use the checklist to assess their school health program. Call (802) 828-3135.
- The book *Health Is Academic: Creating Coordinated School Health Programs* (1998), developed by the **Education Development Center** (EDC) with CDC support, consists of experts' contributions from over 70 professional associations and leaders in health and education. Contact Teachers College Press at (800) 575-6566.
- *Health Is Academic* is supplemented by a continually updated interactive website at www.edc.org/HealthIsAcademic. EDC also publishes the quarterly *School Health Program News*, which reports on activities nationwide.
- The **Institute of Medicine** (IOM) of the National Academy of Sciences published *Schools and Health: Our Nation's Investment* (1997), a major, in-depth review of the history, research findings, and literature pertaining to school health programs with specific recommendations for action. Call the National Academy Press at (800) 624-6242 or visit its bookstore at www.nap.edu.
- The **American School Health Association** (ASHA) offers an extensive variety of publications that address all aspects of school health programs. Call (330) 678-1601, e-mail asha@ashaweb.org, or go to www.ashaweb.org.
- **ETR Associates** offers a broad variety of useful publications on school health programs, including *Step by Step to Health-Promoting Schools: A Guide to Implementing Coordinated School Health Programs in Local Schools and Districts* (1998). Call (800) 321-4407 for a catalog or go to www.etr.org.
- *Great Transitions: Preparing Adolescents for a New Century* (1995) is the concluding report of the **Carnegie Council on Adolescent Development.** An abridged version of this and other major reports is available at www.carnegie.org, or call the Carnegie Corporation of New York at (212) 371-3200.
- "Positive Youth Development in The United States: Research Findings on Evaluations of Positive Youth Development Programs" (1998) is a major study that defines key concepts and documents evidence of program effectiveness. The report was prepared by Richard Catalano, David Hawkins, and others at the **Social Development Research Group** at the University of Washington and is available through the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services at http://aspe.os.dhhs.gov/hsp/PositiveYouthDev99/index.htm.
- The **School Mental Health Project** in the Department of Psychology at UCLA emphasizes a broad perspective of addressing barriers to learning and promoting healthy development. The website offers information on the project's clearinghouse, introductory packets, consultation cadre, newsletter, links to other Internet sites, and electronic networking. Among their materials is *School-Community Partnerships: A Guide.* Contact smhp@ucla.edu, call (310) 825-3634, or go to http://smhp.psych.ucla.edu.

- *Mental Health: A Report of the Surgeon General* discusses children's issues in depth and describes several interagency partnership models for service delivery. It can be downloaded at www.surgeongeneral.gov/library/mentalhealth.
- The **National PTA** has a number of materials available for family members in English and Spanish. Call (312) 549-3253 or visit www.pta.org. An online guide to the *National Standards for Parent/Family Involvement Programs* can be found at www.pta.org/programs/stnrdgd.htm. Many state-level PTAs have also developed related materials.
- The **National Wellness Institute** offers an online resource guide at www.wellnessnwi.org.
- With support from the **BellSouth Foundation,** the EDC produced *Education and Health: Partners in School Reform* (1994), which highlights efforts in 12 communities in nine southern states to establish comprehensive school health programs that address the full range of human needs. Contact the foundation at www.bellsouthcorp.com/bsf.
- *Lessons from the Field* is a four-part series of concise reports that usefully documents the results of the activities undertaken by local education funders who are members of the **Public Education Network.** Call (202) 628-7460.
- Making The Grade is a national program of the **Robert Wood Johnson Foundation,** which researches and supports effective implementation of school-based and school-linked health centers. Call (202) 466-3467 for more information.
- Professional membership organizations that offer specialized technical assistance and guidance on various aspects of school health programs include the following:
    - **American Counseling Association** at (703) 823-9800;
    - **National Association of School Nurses** at (207) 883-2117;
    - **National Association of School Psychologists** at (301) 657-0270; and
    - **National Association of Social Workers** at (202) 336-8227.
- A national outreach campaign called Insure Kids Now is aimed at enrolling eligible but uninsured children in Medicaid by promoting awareness of the federal **Children's Health Insurance Program,** also known as CHIP. Anyone can call (877) KIDS-NOW and be connected with the appropriate state agency.
- Independent researcher **Joy G. Dryfoos** describes school-based programs that are making a difference in the lives of children and adolescents in *Safe Passage: Making It Through Adolescence in a Risky Society* (Oxford University Press, 1998) and *Full-Service Schools: A Revolution in Health and Social Services for Children, Youth, and Families* (Jossey Bass Education Series, 1994).

3. Administration and Evaluation

Administrators set the tone for how faithfully a district or school implements a program and adheres to policy. To enhance success and accountability to taxpayers or trustees, policy must clearly state who is responsible to whom for doing what.

General School Health Sample Policy, Part Three:

RESPONSIBILITIES OF ADMINISTRATORS. The superintendent/school principal/other or his/her designee shall be responsible for:

- preparing a comprehensive plan for eight elements of a coordinated school health program, with input from students and their families;
- ensuring that the various components of the school health program are integrated within the basic operations of the district/school, are efficiently managed, reinforce one another, and present consistent messages for student learning;
- developing procedures to ensure compliance with school health policies;
- supervising implementation of school health policies and procedures;
- negotiating provisions for mutually beneficial collaborative arrangements with other agencies, organizations, and businesses in the community; and
- reporting on program implementation, results, and means for improvement to whom and how regularly.

RESPONSIBILITIES OF THE SCHOOL HEALTH COORDINATOR. Each school/district shall appoint a school health coordinator to assist in the implementation and coordination of school health policies and programs by:

- ensuring that the instruction and services provided through various components of the school health program are mutually reinforcing and present consistent messages;
- facilitating collaboration among school health program personnel and between them and other school staff;
- assisting the superintendent/school principal and other administrative staff with the integration, management, and supervision of the school health program;

- providing or arranging for necessary technical assistance;
- identifying necessary resources;
- facilitating collaboration between the district/school and other agencies and organizations in the community who have an interest in the health and well-being of children and their families; and
- conducting evaluation activities that assess the implementation and results of the school health program, as well as assisting with reporting evaluation results.

RESPONSIBILITIES OF THE SCHOOL HEALTH COUNCIL. A school health council shall be established that is composed of diverse members of the school community representing the eight components of the coordinated school health program, plus members of the community, family members, and students as appropriate. The council shall meet regularly to assess the progress of all aspects of the school health program and assist *district/school* leaders with general oversight, planning, evaluation, and periodic revisions of all aspects of the school health program.

To minimize inefficiency and duplication, the scope of duties, reporting procedures, and means of coordination shall be established in writing for this council and for all other planning committees and advisory councils.

RESPONSIBILITIES OF OTHER ADMINISTRATIVE STAFF. The food service program and its personnel shall be under the general supervision and authority of a food service director who reports to *determined by district or school*. State and district officials retain legal oversight responsibility to ensure compliance with state and federal laws, regulations, and guidelines.

Each middle school and high school shall appoint an athletic and/or student activities director to be primarily responsible for development, implementation, and ongoing administration of the school's intramural and interscholastic athletic programs.

The school health coordinator, food service director, athletic director, and student activities director shall be included as members of site-based management teams, district/school improvement councils, and other governance or advisory bodies as appropriate.

EVALUATION. Multiple indicators shall be used to assess the implementation and results of each component of the school health program. Health-related behaviors of students shall be anonymously surveyed every two years. The evaluation plan shall also include assessments of students' and families' satisfaction with the school health program.

POLICY REVIEW. The *school board/other decision making body* shall review school health policies to assess their effectiveness and make appropriate adjustments at least every three years.

Discussion

Committed leadership has been found to be critical to the success of school-linked comprehensive services.[31] School health components such as nursing services, school food services, and physical education typically have operated in isolation from the rest of the school or school district administration. A truly coordinated school health program requires that higher levels of management be involved with oversight and that school health staff are fully integrated as valued members of school management teams.

Policy versus Management

As noted previously, this policymaking guide does not attempt to provide operational details on how to plan and manage a school health program. Policy should express *what* should be done, *why* it should be done, and *who* should do it. Regulations and other types of administrative guidance typically outline *how* to accomplish set policy goals.

Accountability is one of the most important policy issues for local and state education decision makers to consider. Policies need to make clear to everyone involved *who* is responsible to *whom* for *what.*

Fiscal accountability is critical in this era of tight school budgets. Yet policymakers need to consider more than the financial bottom line. Governing authorities also need to make clear that they will hold schools accountable for achieving the goals and purposes of school health policies.

Policies should spell out the means for holding the responsible parties accountable. Different jurisdictions use a variety of means to ensure accountability. These include some mix of individual job performance evaluations, state/district review processes, program assessments, student assessments, and school accreditation processes.

School health coordinator

Appointing a dedicated individual who is responsible for school health program coordination can help reduce ambiguity about who should be doing what, which often impedes program implementation.[32] A school health coordinator can help ensure that the various program components are mutually reinforcing each other's efforts.

In one model of such a position, job functions include:[32]

- committee coordination;
- fiscal planning
- liaison with district and state agencies; and
- responsibility for the three coordinated school health program components that do not correspond with discrete professional disciplines within the

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school: health promotion for staff, healthful environment, and community and parent involvement.

School health councils

Much of the management of a coordinated school health program at the state, district, or school level can be achieved by appointing a standing school health council. At the school level, active school health councils can provide personnel and parents with a sense of program ownership and reinforce the institution's commitment to school health.

Many states, districts, and schools have successfully established school health councils.[33] A 1994 national survey found that 33 percent of school districts and 19 percent of secondary schools had such councils.[34] The school constituents most commonly represented on these councils were teachers, administrators, school nurses, and counselors; more than half the school health councils had representation from these groups. However, at both the district and secondary school levels, only eight percent of the health councils had food service personnel as members.

Planning a school health program

The process of developing a comprehensive plan for a coordinated school health program should involve gathering input from all relevant constituents of the school community. Widespread collaboration in the planning process helps to ensure that a policy is adapted to local circumstances and is well crafted. Such collaboration also helps build widespread awareness and support for the policy.

Among the people who should be involved in developing a plan are the following:

- school health professionals, including health and physical educators, nurses, counselors, and food service program staff;
- other teachers, administrators, janitors, bus drivers, secretaries, and school staff;
- family members and students (maturity permitting);
- health professionals in the community; and
- other influential figures in community life.

Activities and educational objectives should address local needs and problems. Differences in health status among distinct regions and groups argue for the need to base policies on local data that might be available from public health departments. Planners should conduct needs assessments with community input; adapt activities to the interests and preferences of different ethnic, religious, and social groups; and foster effective school/community collaboration.

Interagency collaboration

Ensuring the involvement of public health professionals and others in the community is critically important. Limited resources call for a coordinated approach to school health programs. By addressing students' well-being and ability to learn in a less fragmented way, schools and communities can avoid gaps, collaborate on overlapping functions, and eliminate unnecessary duplication of efforts. For example, school-based activities should be well coordinated with community-wide health promotion programs, such as efforts to prevent tobacco use, to enhance the effectiveness of both.

More than 25 states have established formal mechanisms for collaboration on statewide issues that affect children and families (see box below, "New Roles for States"). State agencies can be very useful in helping to

New Roles for States

The Michigan Model

More than 115 voluntary, professional, and community groups collaborate with several state agencies to operate the Michigan Model for Comprehensive School Health Education, an efficient delivery mechanism for school health resources and programs. The model is designed to help schools sort out the abundance of categorical programs and well-meaning special interests that sometimes compete with each other for the limited amount of time in the school day. Implemented statewide through 26 regional sites, the Michigan Model provides training, curricular materials, and other resources to the 95 percent of public school districts and 180 private schools in the state who voluntarily participate. The nationally recognized model has positively influenced student behaviors, has been designated one of the country's best substance abuse prevention programs, and has garnered high levels of satisfaction on parent surveys.[35]

The Wisconsin Framework

The Wisconsin Framework for Comprehensive School Health Programs describes a multi-strategy approach that seeks to address the entire range of risk behaviors among adolescents and promote the health, well-being, and positive development of students and other members of the school community as an integral part of a school's overall mission. Its purposes are as follows:

1. to communicate the critical and essential role of schools in the positive development of healthy, resilient, successful learners;
2. to serve as a "sense-maker" or "organizer" for schools concerning how to create an integrated, comprehensive service delivery system;
3. to help schools define their role and capacity in addressing the health and safety needs of children within the school setting; and
4. to act as a functional system for the Department of Public Instruction for integrating the services, programs, and funds related to prevention and to the health and positive development of children.

The framework is a collection of empirically supported strategies that are most effective and efficient when implemented in a connected and integrated manner. The strategies address a healthy school environment; curriculum, instruction, and assessment; pupil services; student programs; adult programs; and family and community connections.[36]

New Jersey's School-Based Youth Services

Since 1988 New Jersey has supported the School-Based Youth Services Program, a statewide effort to place comprehensive services in or near secondary schools. The program's goal is to provide adolescents, especially those at risk of failing school or dropping out of school, with opportunities to complete their education, obtain skills that lead to employment or additional education, and lead mentally and physically healthy and drug-free lives. The program operates in more than 30 school districts with at least one site per county.[37]

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clear barriers to interagency collaboration at the local level. States also have a role in helping schools secure applicable relief from federal and state regulations that sometimes can be cumbersome.

Funding

Education funding is stretched thin in many states and school districts, which limits the ability of schools to finance ancillary services that support education. Basic educational resources allocated through funding formulas are rarely used to support more than classroom health instruction and student counseling services. Schools face an uncomfortable dilemma of whether to offer costly supplemental services that respond to children's broader needs or to allow those unmet needs to negatively affect learning. Most people agree that schools cannot, and should not, bear the financial costs of high-quality school health programs alone.

Many states and local districts have been creative at finding ways to fund programs that address the nonacademic needs of students. Typically, school health programs use a combination of resources including state and federal appropriations (see box, "Some Federal Sources of Funding"), excise taxes, and lottery revenues. Some state legislatures appropriate money specifically for school-based health programs, usually in the form of competitive grants.

Private foundations and local businesses are often tapped to support specified portions of school health programs. Many state and local health, social service, and recreation agencies and youth-serving organizations also provide financial and in-kind resources. One study found that nearly three times as much money is available outside of education to serve the nonacademic needs of children and adolescents than what the education sector spends.[38]

An advantage of this "unsystematic funding system" is that it provides great flexibility to tailor a program to local needs. The challenge is to identify, blend, and efficiently deploy the disparate resources.

Some Federal Sources of Funding

- The Safe and Drug-Free Schools and Communities Act, administered by the U.S. Department of Education, can be used to finance school health education and various student support services.
- In addition, a limited amount of the Title I program, also from the U.S. Department of Education, can be used for student support services.
- The U.S. Department of Education administers the 21st Century Community Learning Centers grant program to help schools expand learning opportunities after school, on weekends, and during summer breaks.
- Several federal grant programs administered by the U.S. Department of Health and Human Services are commonly used to fund elements of school health programs. These include the Maternal and Child Health Services Block Grant, the Community Mental Health Services Block Grant, and the Substance Abuse Prevention and Treatment Block Grant.
- An increasing number of school-based and school-linked health centers have been able to obtain Medicaid funds to serve eligible students.

This can mean that staff might have to devote a substantial amount of time to fundraising and grant administration. To assist schools and districts, CDC's School Health Finance project maintains a regularly updated database of information on various sources of federal, state, and private sector funding sources (see the resource list at the end of this section).

Evaluation

Evaluation is critically important to education decision makers in a number of ways. It helps them to:

- develop well-designed policies and programs;
- ensure accountability to funding agencies;
- weigh and compare various solutions to identified problems;
- help determine whether to support or oppose particular programs or policies;
- justify decisions to the general public, the legislature, and the news media;
- help build consensus among people with different political views; and

Collecting Vital Information: The YRBSS

The Youth Risk Behavior Surveillance System (YRBSS) provides timely information about behaviors practiced by young people that put their health at risk. Developed in collaboration with partners in the federal, state, and private sectors, this voluntary system includes a national survey and surveys conducted by state and local education agencies. State and local health and education officials use YRBSS data in a variety of ways to:

- **Implement or modify programs to address the behaviors of young people in a specific area.**
  South Dakota used YRBSS data from Native American young people to help implement school health education in Bureau of Indian Affairs schools.
- **Set program goals and objectives and monitor the progress toward those goals.**
  Delaware used its YRBSS data to help develop its five-year comprehensive plan to reduce sexually transmitted diseases, including HIV/AIDS.
- **Create awareness of the extent of risk behaviors among young people.**
  Many states and cities, including Alabama, Dallas, and Miami, have used YRBSS data to enhance teacher training programs.
- **Promote state-level changes that support specific health education curricula and coordinated school health programs.**
  West Virginia used YRBSS data to help ensure that schools develop local school improvement councils to address issues related to children's health and safety.
- **Provide evidence-based data to support the need for health education.**
  Maine used its YRBSS data to help obtain a grant to support mental health services in school-linked clinics.

With technical assistance from the CDC, state and local department of education staff conduct a Youth Risk Behavior Survey (YRBS) every two years. Staff can add or delete questions in the core questionnaire to better meet the interests and needs of individual state or local school districts. School-based surveys were last conducted in 1997 among students in grades nine through twelve in 39 states, 16 large cities, and four territories.

—Centers for Disease Control and Prevention[3]

- make incremental improvements in policies and programs on a continuous basis.

A good evaluation plan does not need to be intimidatingly extensive, resource-intensive, or put undue burdens on practitioners. Its critical function is to answer some basic questions that are very important to policymakers, family members, and the general public:

- ✓ What's working?
- ✓ What's not working?
- ✓ Are we making any difference?
- ✓ How can the program be made better?

Several types of evaluation are relevant to school health programs. A useful plan includes elements of the following types of evaluation:

- *process evaluation* focuses on measuring participation and utilization rates to track what is happening. Student and family satisfaction surveys are process evaluations;
- *program fidelity evaluation* focuses on ensuring that a program is being faithfully implemented as intended; and
- *outcome evaluation* focuses on results, such as students' health status, absenteeism and dropout rates, and changes in behavior. CDC's Youth Risk Behavior Surveillance System is used by many states and districts to assess behavior change (see box, "Collecting Vital Information: The YRBSS," on the preceding page).

Resources

- *Finding Common Ground: Creating Local Governance Structures* (1993) from the **Southwest Educational Development Laboratory** (SEDL) describes how states and localities are creating a variety of new local governance structures to provide a "seamless web" of high-quality, comprehensive, continuous services for children and their families. The document addresses agenda setting and strategy development, developing new service capacities, coordinating fiscal strategies, maintaining accountability, and state support for local governance. It is available by calling (512) 476-6861 or can be downloaded at www.sedl.org/pubs/catalog/items/pol13.html.

- *Achieving Goal V: Assessment and Planning Guide for Goal Five of Blueprint 2000* (undated) from the **Florida Department of Education** provides guidance on establishing School Advisory Councils to address school health, substance abuse, safety, and civil rights issues. Call the Florida Department of Education Prevention Center at (904) 488-7835.

- The **American Cancer Society** (ACS) has published *Improving School Health: A Guide to School Health Councils.* The organization also provides technical assistance related to participation on a school health council. Call (800) ACS-2345 or go to www.cancer.org.

- CDC maintains an Internet website for the regularly updated **School Health Finance project** database of information on various sources of federal, state, and private sector funding sources. Go to www.cdc.gov/nccdphp/dash/funding.htm.

- The **National Conference of State Legislatures** (NCSL) operates two searchable databases: one on state funding sources to support school health programs and the procedures required to access the funds, and the other on states' use of federal block grants. Go to www.ncsl.org/programs/health/pp/schlfund.htm.

- The **Finance Project**, a national initiative funded by a consortium of private foundations, has produced a useful series of working papers on salient issues related to financing for education and other children's services. Call (202) 628-4200 or go to www.financeproject.org.

- *Incorporating Health-Related Indicators in Education Accountability Systems* from the **Council of Chief State School Officers** (CCSSO) contains practical suggestions for selecting health indicators to incorporate into overall education accountability systems. Call (202) 408-5505.

- The **Virginia State Department of Education** has published a model survey entitled "Healthy Schools Make Sense: Evaluating Your School Health Program" (undated). Write to P.O. Box 2120, Richmond, VA 23216.

- **ETR Associates** offers *Step by Step to Comprehensive School Health: The Program Planning Guide*, which schools and districts can use to assess their programs. Call (800) 321-4407.

4. Health Education

A sound health education policy emphasizes that instruction must do more than impart information. Effective health instruction involves learning and practicing *skills* for making wise personal decisions about maintaining health-enhancing daily habits and avoiding behaviors that can have negative health consequences.

General School Health Sample Policy, Part Four:

INTENT. A comprehensive program of health education that is designed to promote healthful living and discourage health-risk behaviors shall be taught at every grade level, pre-kindergarten through twelfth grade. Health-literate graduates of the school system shall be able to:

- comprehend concepts related to health promotion and disease prevention;
- access valid health information and health-promoting products and services;
- practice health-enhancing behaviors and reduce health risks;
- analyze the influence of culture, media, technology, and other factors on health;
- use interpersonal communication skills to enhance health;
- use goal-setting, decision-making, and self-management skills to enhance health; and
- advocate for personal, family, and community health.

INSTRUCTIONAL PROGRAM DESIGN. The health education program shall be an integral part of a coordinated school health program, be consistent with the state's *standards/guidelines/frameworks*, and be reviewed by the school health council. The health education program shall:

1. utilize educational theories and methods that have credible evidence of effectiveness;
2. emphasize learning and practicing the skills students need for healthful living;
3. build functional knowledge and skills from year to year (i.e., be sequential in design);
4. include accurate and up-to-date information;

5. use active, participatory instructional strategies and techniques;

6. be appropriate to students' developmental levels, personal behaviors, and cultural backgrounds;

7. be consistent with community standards;

8. focus on the behaviors that have the greatest effect on a person's health and emphasize the short-term and long-term consequences of personal health behaviors;

9. encourage students to assess their personal behaviors and habits, set goals for improvement, and resist peer and wider social pressures to make unhealthy choices;

10. stress the appealing aspects of living a healthy lifestyle;

11. address students' health-related concerns;

12. utilize curriculum materials that are gender-neutral and nonstereotyping;

13. assess students' achievement of health knowledge and skills with assessment instruments aligned with the curriculum;

14. be appropriately adapted to the special needs of students with disabling conditions, students with limited English proficiency, and students in alternative education settings;

15. be taught by well-prepared instructors with adequate support;

16. be allocated enough instructional time to achieve the program's goals;

17. be taught in classes that are the same average size as classes in other subject areas;

18. include means for program evaluation; and

19. involve parents and families as active partners in their children's learning.

GRADING. All students shall be regularly assessed for attainment of the health education learning objectives. Course grades shall be awarded in the same manner as in other subject areas and be included in calculations of grade point average, class rank, and academic recognition programs such as honor roll.

Students' results on health-related portions of state and district academic achievement tests shall be considered the same as in other subject areas for determining school progress indicators and in application of consequences in accordance with the established provisions of the *state/district* accountability system.

CURRICULUM INTEGRATION. Health education topics shall be integrated into the instruction of other subject areas to the greatest extent possible. Such cross-teaching is intended to complement, not substitute for, a comprehensive health education program.

PARENTAL REVIEW. Parents and guardians shall have convenient opportunities to preview all curricula and materials. A student may be excused from receiving school instruction in specific topics upon the written request of a parent or legal guardian. The parent/guardian must ensure that the topics the student is excused from are learned at home or elsewhere, and the student will be assessed for attainment of the health education learning objectives in the same manner as students not excused.

COLLABORATION. To the extent practicable, school staff shall cooperate with other agencies, organizations, and individuals conducting health education in the community. Guest speakers invited to address students shall receive appropriate orientation to the relevant policies of the *school/district*. School staff are encouraged to work with community organizations to provide opportunities for student volunteer work related to health.

Discussion

A good health education program, implemented as designed, can bring about noteworthy changes in behavior among significant numbers of students. For example, an important study from the University of Washington has recently shown the value of an elementary school health education program (see box, "Positive Outcomes in Seattle," on the following page).

Surveys consistently find solid support from parents and the general public for teaching health education in schools (see box, "In Survey, Adults Rank Academics Below Health").

Quality health instruction is consistent with the goals of mainstream

In Survey, Adults Rank Academics Below Health

Most state standards require students to learn a heavy dose of academics, but that may not be what Americans value most, a survey suggests.

The more than 2,500 adults surveyed ranked selections from state and national standards in health information and work-related skills higher than those from history, language arts, mathematics, and other subjects....

More than seven in 10 rated health information as "definitely" important, and more than six in 10 gave a strong nod to skills related to work, such as the ability to work effectively in an organization.... The study, "What Americans Believe Students Should Know," found that, among other priorities, adults want students to understand the effect of substance use and abuse, the relationships between families and individual health, and disease prevention and control.

—Education Week[13]

Positive Outcomes in Seattle

A 12-year study of a multi-ethnic sample of nearly 600 children from 18 elementary schools serving high-crime neighborhoods in Seattle found a broad range of significant, long-lasting, positive effects from a school health intervention program. The study shows that, compared with a control group that was not exposed to the elementary school intervention, at age 18 children who received the program were:

- 19 percent less likely to commit violent acts;
- 38 percent less likely to indulge in heavy drinking;
- 13 percent less likely to engage in sexual intercourse;
- 19 percent less likely to have had multiple sex partners; and
- 35 percent less likely to have caused a pregnancy or become pregnant.

In addition, the children who received the intervention achieved better academic performance and recorded higher overall grade point averages in school.

The program worked with teachers, students, and parents. Teachers were given five days of special training each year to learn skills such as interactive teaching, classroom monitoring, cooperative learning, and proactive disciplinary skills to prevent problems from arising. Children, meanwhile, were taught impulse control, how to get what they want without aggressive behavior, and how to recognize the feelings of other people. Parents were taught a variety of skills including positive reinforcement, monitoring their children, and how to reduce their children's risk of early alcohol and drug use.

—Hawkins, et al.[40]

education reformers and the business community who want schools to cultivate skills such as information finding, critical examination, informed skepticism, effective communication, interpersonal negotiation, and the ability to work well in groups.

Pointing out that "health education instructional objectives reinforce the core curriculum and develop important workplace process skills," West Virginia's Healthy Schools staff in the state education agency extensively cross-referenced its health education objectives with the state's objectives for workplace process skills and the content objectives of the "core areas" of English language arts, math, social studies, and science at each grade level.[41] The effort demonstrated how health education can reinforce the core curriculum and how the core curriculum can incorporate health topics. Similarly, Vermont's *CSHP*

Higher Order Thinking Skills

Today's state-of-the-art health education is much more than learning facts about anatomy, the kind of education most of us experienced as youngsters. Where quality programs are in place students learn how to be aware of and critically assess the health messages they get from popular culture and advertising and how to find reliable health information. They learn to assert themselves, resist peer pressure, and practice other communication skills. They research health issues faced by their local communities.

Such lessons are not taking valuable class time away from learning "higher order thinking skills" and other workplace skills demanded by employers. On the contrary, good quality health education taught by well-prepared teachers enhances these very skills.

—Dorothy Beardmore, President,
Michigan State Board of Education[38]

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Guidelines (1996) provides examples of the standards from *Vermont's Framework of Standards and Learning Opportunities* that apply specifically to health, safety, and physical education.

Health education standards

A recently-developed set of national health education standards (see box below) embody best practice guidelines as jointly determined by a group of national organizations that represent health education professionals. Of 49 states that have or are developing educational standards, 28 include health and/or physical education in their sets of standards.[42] Some closely follow the national health education standards; others do not. State health education standards documents go by many names, including Practical Living Studies (Kentucky), Skills for a Healthy Life (Alaska), Physical Development and Health (Illinois), Responsible Healthy Lifestyles (Utah), and Personal Development (Vermont). The different names indicate different philosophical approaches and suggest various ways to integrate school health education into the larger school mission.

Health curriculum content

The sample policy in this section addresses the attributes and expected results of a high-quality health education curriculum, but—

National Health Education Standards

In 1995 the American Cancer Society (ACS), the American School Health Association (ASHA), the American Association for Health Education (AAHE), the American Public Health Association (APHA), and the Society of State Directors of Health, Physical Education and Recreation (SSDHPER) jointly developed voluntary national school health education standards to help guide states, districts, and schools.

The seven broad, skills-based standards, listed in the first paragraph of this section's sample policy, are intended to promote "health literacy," which is defined as the capacity of individuals to obtain, interpret, understand, and use basic health information and services. Four characteristics were identified as essential to being a well-educated, health-literate person. Such an individual must be a critical thinker and problem solver; a responsible, productive citizen; a self-directed learner; and an effective communicator.

Specific performance indicators that accompany each standard help educators determine what knowledge and skills students should possess by the time they complete grades four, eight, and eleven. Also included are "opportunity-to-learn standards" that provide direction for policies, resources, and activities of local education agencies, communities, state education agencies, state health agencies, national organizations, and institutions of higher education responsible for teacher preparation.

The standards are based on concepts and skills; they intentionally do not detail specific information all students should know about any single subject, such as nutrition or human anatomy. In part this is because traditionally taught health education has tended to put too much emphasis on learning facts. The skill emphasis is thought to be appropriate because health education is different from instruction in other subjects in that it aims to influence student behavior *outside* of the classroom.

Educators are encouraged to teach the traditional content areas of health education within the skills framework outlined in the standards and to focus on the most important health-risk behaviors, including lack of physical activity, unhealthy eating, and substance abuse.

—American Cancer Society[43]

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Framework for Healthful Living Education

Today, health status is determined more by one's own behaviors than by advances in medical technology, availability of health services, or other factors, and research demonstrates that education in schools can influence the health-related behaviors of students. This research indicates that Healthful Living Education is most effective and efficient when it:

- focuses on health-related behaviors;
- has a positive, wellness orientation;
- is based on skill development;
- approaches health comprehensively;
- involves students in actively learning;
- matches educational priorities with the appropriate grade levels;
- is culturally sensitive;
- has continuity through the grade levels;
- has adequate blocks of time devoted to it;
- is taught by well-informed teachers who are comfortable with the content and methods; and
- is reinforced by school policies, services, and environment, by parents, by peer educators, by community programs and media, and by school staff modeling.

—North Carolina Department of Education[44]

like the national health education standards— the policy does not outline specific course content. Some states have produced health education frameworks that delineate specific topics, leaving local districts and schools to focus on methodological issues. Other states offer curriculum guidance that is not mandatory. Yet others leave health education entirely to the discretion of local school officials.

A good health education program needs to address the six categories of priority risk behaviors identified by CDC, which are listed earlier in this chapter. School leaders looking for course content topics can:

- obtain detailed guidance from the CDC guidelines for school health programs that address physical activity, healthy eating, and prevention of tobacco use;

Essential Knowledge and Skills for Health Education

In health education, students acquire the health information and skills necessary to become healthy adults and learn about behaviors in which they should not participate. To achieve that goal, students will understand the following:

- students should first seek guidance in the area of health from their parents;
- personal behaviors can increase or reduce health risks throughout the lifespan;
- health is influenced by a variety of factors;
- students can recognize and utilize health information and products; and
- personal/interpersonal skills are needed to promote individual, family, and community health.

—Texas Education Code[45]

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CDC's Research to Classroom: Programs That Work

CDC's Research to Classroom (RTC) project identifies programs with credible evidence in reducing health-risk behaviors among young people as "Programs That Work." The project also provides information and training for interested educators from state and local education agencies, departments of health, and national nongovernmental organizations.

CDC staff review electronic databases, literature reviews, meta-analyses, and reports on evaluation studies that meet the criteria for consideration. During the RTC review process CDC appoints an expert evaluation panel to assess the validity of the program's evaluation and an expert program panel to assess the feasibility of replicating the program. If both panels recommend adoption of the curriculum, based on attainment of identified criteria, CDC designates the curriculum as a Program That Works.

So far, CDC has identified curricula for sexuality and prevention of tobacco use. Programs That Work in preventing tobacco use prevention are described in a later chapter of this guide ("Policies to Discourage Tobacco Use," page F-22).

The CDC identifies and disseminates information on these Programs That Work to help inform local and state choices. The choice to adopt a curriculum ultimately rests with local decision makers and should address community standards and needs.

- examine various state curriculum frameworks;
- obtain advice and materials from national associations and other organizations;
- take advantage of CDC's Research to Classroom project that identifies specific "Programs That Work," which are curriculum programs that show credible evidence of effectiveness in reducing health-risk behaviors among young people (see box above); and/or
- use other commercial materials.

Creative teachers can supplement the curriculum with materials based on local needs and students' expressed interests. For accuracy and completeness, the school health council should review all curriculum materials that are proposed for adoption.

Health education assessments

State-of-the-art assessments that align with the national health education standards are available. Thirty-one states participated in the Health Education Project of the Council of Chief State School Officers (CCSSO) to develop the validated and pilot-tested assessment package called *HealthHELP* (see the resources list at the end of this section). The package consists of several different types of assessment instruments, including multiple-choice test items, open-ended scenarios that require written responses, and extended projects for student portfolios. Also included are a scoring system and teacher professional development materials and activities.

The assessments are designed to demand more than simple knowledge of health-related facts; they provide an opportunity to assess health concepts and skills in scenarios that approximate real-world situations. However, the assessments can track only whether students "know how

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to" engage in healthy behaviors and "know why" those behaviors are healthy, but not how students are actually behaving. Student assessments need to be supplemented with behavioral surveys such as CDC's Youth Risk Behavior Survey (YRBS) to obtain a complete picture of students' "health literacy."

Resources

- *Health for Success: The National Health Education Standards* is online from the **American Cancer Society** (ACS) at www.cancer.org/cshe/cshe.html. Hard copies are available from the **American Association for Health Education** (AAHE) at (800) 321-0789.
- **Putnam Valley School District** in New York State maintains a clearinghouse for state standards in every subject at http://putwest.boces.org/Standards.html.
- *Content Knowledge: A Compendium of Standards and Benchmarks for K-12 Education* from the **Mid-continent Regional Educational Laboratory** (McREL) identifies and articulates content standards and benchmarks from various national groups and includes links to the standards documents. It can be found at www.mcrel.org/standards.
- CDC's Division **of Adolescent and School Health** (DASH), through its Research to Classroom Project, works to identify specific curriculum "Programs That Work" that have scientifically credible evidence of reducing health-risk behaviors among students. For more information go to www.cdc.gov/nccdphp/dash.
- The **Education Development Center** (EDC) offers *Educating for Health* and *Choosing the Tools*, guides to assist in choosing health education curricula. Call (617) 969-7100.
- *HealthHELP*, the health education and assessments CD-ROM, is available from the **Council of Chief State School Officers** (CCSSO) at (202) 408-5505.

5. Well-Prepared Staff

The effective teaching of health education and physical education programs requires that teachers know bodies of knowledge and can apply instructional skills that are uniquely different from the knowledge and skills necessary to teach other subject areas. Health education and physical education aim at influencing students' personal health *behaviors*, not just building their academic knowledge and developing their cognitive skills. Policies need to reflect the distinctive aspects of teaching about health behavior. Policies also need to ensure that other school health professionals are well prepared and well supported.

General School Health Sample Policy, Part Five:

QUALIFICATIONS. All personnel involved in the school health program shall possess the necessary qualifications and training essential to their duties. Professional staff shall be currently licensed, certified, and/or recertified according the requirements established by *state board or other agency* for the positions in which they are employed and are expected to follow the performance and ethical standards established by their professional organizations.

Health and physical education teachers shall be required to periodically demonstrate their abilities to apply the content knowledge and instructional skills that are critical to the successful teaching of health and physical education.

PROFESSIONAL DEVELOPMENT. All personnel involved in the school health program shall participate in ongoing professional development activities that are directly related to their responsibilities. In particular, instructional staff who teach health topics shall satisfactorily complete professional development activities that provide basic knowledge about health and health education, including practice with teaching strategies designed to influence students' health-related behaviors and attitudes.

Professional development programs shall:

- respond to the professional improvement needs of staff and schools;
- be designed to transfer knowledge and skills based on theories and methods proven effective by published research;
- encourage reflection and professional discourse among peers about classroom practice;
- be made available to staff at their place of work to the greatest feasible extent;

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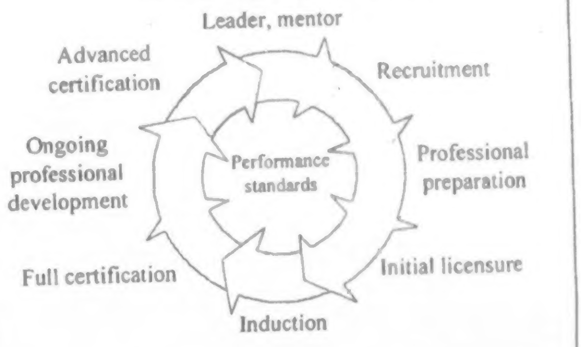
- involve staff unions and professional associations in planning and implementation;
- provide necessary information about school health-related standards, guidelines, frameworks, regulations, policies, and recommendations of *state/district/school* and federal agencies; and
- provide relevant information about other disciplines to foster efficient collaboration among professionals.

Discussion

Many states are currently moving in the direction of adopting coherent policy frameworks that address the preparation and continuing development of school professionals. Informing these frameworks is a clear vision of effective teaching and performance standards that reflect the essential duties of the teaching profession. Similar performance standards are being established for other school health professional areas, including school nursing, food service, athletics, and administration. Such performance standards should underlie other policies that address each stage of the "staff development cycle" at the state and/or local level, as appropriate:

- ○ programs for attracting and recruiting a diverse pool of talented and committed candidates;
- ○ quality preservice preparation programs that meet established standards, offered at colleges of education and other institutions of higher education;
- ○ initial licensure requirements that may include appropriate tests or portfolios of accomplishments;
- ○ induction efforts that orient, guide, and actively support new staff;
- ○ full certification requirements that could be based on years of experience, additional coursework taken, and/or observations of demonstrated competence;
- ○ ongoing professional development programs tailored to the job performance needs of staff;
- ○ opportunities for advanced certification with public recognition of professional mastery; and
- ○ involvement of accomplished professionals in mentoring

The Staff Development Cycle



Effective Teaching

Research has discovered a great deal about effective teaching and learning: We know that students learn best when new ideas are connected to what they already know and have experienced; when they are actively engaged in applying and testing their knowledge using real-world problems; when their learning is organized around clear, high goals with lots of practice in reaching them; and when they can use their own interests and strengths as springboards for learning. When teachers can work together to build a coherent learning experience for students throughout the grades and within and across subject areas—one that is guided by common curriculum goals and expectations—they are able to engender greater student achievement.

We also know that expert teachers use knowledge about children and their learning to fashion lessons that connect ideas to students' experiences. They create a wide variety of learning opportunities that make subject matter come alive for young people who learn in very different ways. They know how to support students' continuing development and motivation to achieve while creating incremental steps that help students progress toward more complicated ideas and performances. They know how to diagnose sources of problems in students' learning and how to identify strengths on which to build. These skills make the difference between teaching that creates learning and teaching that just marks time.

—National Commission on Teaching & America's Future[47]

other staff and/or lending expertise to policy development activities.

Alignment across the policies is critical so that each interconnected stage of the staff development cycle complements the other stages.[46] Following is a discussion of several of these stages as they pertain to school health programs.

Health Educator Competencies

Because effective health education is predicated on assisting individuals, families, and communities to learn and carry out the behaviors important to their well-being, the competent health educator must possess a number of competencies emanating from three broad areas of knowledge: 1) the methods and processes of health education practice; 2) content that embodies major health issues confronting the society; 3) the obligations one assumes on becoming a professional health educator (a health education specialist), and the accumulated experience of the practice of health education over time (professional socialization).

—American Association for Health Education[48]

Preservice preparation

The National Council for Accreditation of Teacher Education (NCATE) has developed various sets of standards for teacher preparation programs in association with numerous professional organizations, including the American Association for Health Education (AAHE)[48] (see box, "Health Educator Competencies"), the National Association for Sport and Physical Education (NASPE),[49] and the National Association of School Psychologists (NASP).[50] Many states have adopted or adapted the NCATE standards.

In addition, NCATE is in the process of developing a new system of performance-based standards for teacher preparation programs. Their draft standards for elementary-level teacher preparation programs incorporate standards for health

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and physical education (see box, "Standards for Colleges of Education").

Licensure and certification

State education agencies attempt to ensure that educators (teachers, administrators) and other school professionals (counselors, school nurses) have the necessary qualifications by requiring them to be licensed and/or certified. Local districts and schools are free to make their own staffing and hiring decisions so long as their employees have the proper state endorsements. Local officials are also free to establish more rigorous qualifications than what the state decrees.

Each state sets its own requirements for licensure/certification. Typically either the state board of education or a distinct professional standards body is responsible for establishing the requirements; in a few states, the legislature must endorse them. The requirements vary widely among states. Approval usually depends on candidates having passed specified courses of study at accredited institutions of higher education.

Some states also require standardized examinations and/or performance observations by master teachers. Increasingly, states are requiring extended periods of supervised probation for new teachers.

Standards for Colleges of Education

The National Council for Accreditation of Teacher Education (NCATE) is developing a model for a "performance-based" approach to program quality review in accreditation of elementary teacher preparation programs. The following draft standards describe what candidates for teaching elementary students need to know and be able to do:

Standard 2g. HEALTH EDUCATION—Candidates know, understand, and use the major concepts in the subject matter of health education to create opportunities for student development and practice of skills that contribute to good health;

Supporting explanation: Candidates understand the foundations of good health, including the structure and function of the body and its systems and the importance of physical fitness and sound nutrition. They help students understand the benefits of a healthy lifestyle for themselves and others as well as the dangers of diseases and activities that may contribute to disease. Teacher candidates are alert to major health issues concerning children and the social forces that affect them, and of the need to impart information on these issues sensitively. They address issues in ways that help students recognize potentially dangerous situations, clarify misconceptions, and find reliable sources of information.

Standard 2h. PHYSICAL EDUCATION—Candidates know, understand, and use—as appropriate to their own understanding and skills—human movement and physical activity as central elements to foster active, healthy lifestyles and enhanced quality of life for elementary students;

Supporting explanation: Candidates understand physical education content relevant to the development of physically educated individuals. They structure learning activities to ensure that students demonstrate competence in many movement forms, and can apply movement concepts and principles to the learning and development of motor skills. Teacher candidates know that physical inactivity is a major health risk factor in our society and recognize the critical importance of physically active lifestyles for all students. They help students develop knowledge and skills necessary to achieve and maintain a health-enhancing level of physical fitness. Teacher candidates appreciate the intrinsic values and benefits associated with physical activity. They are able to structure movement experiences that foster opportunities for enjoyment, challenge, self-expression, and social interaction and that elicit responsible personal and social behavior and respect for individual differences among people in physical activity.

—National Council for Accreditation of Teacher Education[31]

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Each state also categorizes its endorsement areas differently. Some offer a combined certificate for health and physical education, whereas many others separate the two. A certificate can be broad (such as for generalist elementary school teachers) or narrow (such as for secondary-level physical education teachers).

Licensure/Certification for Educators

States are not consistent with their use of the terms *licensure* and *certification*, which can cause confusion. Although these terms are often used interchangeably, a subtle distinction can be drawn.

***Licensure* often refers to the initial endorsement of an educator upon graduation from a preservice education program. Candidates might be required to achieve a passing score on a qualifying test.**

***Certification* typically refers to a higher level of endorsement based on a person's demonstrated skills and/or postgraduate coursework. Certificates are generally granted for a specified duration and must be renewed. A state may offer several levels of certification.**

The 1994 School Health Policies and Programs Study found that 35 states require health education certification for secondary school health education teachers, 22 of which combine physical education and health education into one certificate. At the elementary school level, only three states require certification for teaching health education, and eight states require it for teaching physical education.[52]

To ensure that students are taught by well-prepared and well-qualified teachers, health and physical education professional associations suggest that state certification agencies should:

- establish separate teaching certificates for health education and physical education;
- offer certificates for different levels (e.g., preschool and early elementary school, elementary school, middle school, and high school);
- require that all generalist teachers (preschool, elementary school, and middle school) pass courses or demonstrate their competence at applying the skills uniquely required to effectively teach health education; and
- allow schools to assign teachers to courses they are not properly certified to teach only when a certified teacher cannot be found and only on a temporary basis with the stipulation that such teachers receive the necessary training if they are to continue teaching the class.

Most states license or certify school professionals for certain periods of time: five years is common. Educators then have to meet additional requirements to renew a certificate. Typically, the requirements specify a certain number of course credits a person must have taken. Increasingly, states are providing more direction to try to ensure that such courses and other professional development opportunities are directly relevant to the educator's daily duties.

More and more states are also requiring evaluations of observed performance for recertification. This is in response to criticisms that "paper qualifications" do not necessarily translate into good job performance.

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Many states are now taking a critical look at their licensure, certification, and recertification requirements to make sure they are aligned with student academic standards and other policies. The trend is toward fewer certification categories and broader areas of endorsement. Those with an interest in school health programs should stay involved in these discussions to ensure that the decision makers are fully informed.

Advanced certification

The National Board for Professional Teaching Standards (NBPTS) operates a national, voluntary system to assess and certify teachers who meet high and rigorous standards for what accomplished teachers should know and be able to do. National Board Certification is intended to be a symbol of professional teaching excellence and is designed to complement, not replace, state licensing/certification. State licensing systems generally set minimal standards for novice teachers; in contrast, National Board Certification measures experienced teachers' skills against very rigorous standards. Many states offer substantial bonuses or salary increases to National Board-certified teachers.

Among the 30 sets of advanced standards NBPTS is currently in the process of developing are standards for physical education and health teaching for each of two broad age groups: ages 3–11 and 12–18+. Policymakers with an interest in fostering quality school health programs should encourage all health and physical education teachers to work toward National Board certification as a personal and professional goal.

Professional development

In a 1994 survey, nearly 9 of 10 physical education teachers expressed the desire for additional professional training; topics related to lifelong health promotion were mentioned most often.[53] Schools have long devoted resources to staff professional development by sponsoring in-service workshops and facilitating access to higher education. Yet often there has been little or no connection between the courses taken and current teaching assignments or school needs. When budgets are tight, professional development is often one of the first items to be scaled back. Sometimes collective bargaining provisions shape staff development offerings instead of instructional needs.

In recent years several groups— including the U.S. Department of Education,[54] the National Staff Development Council (NSDC),[55] the Consortium for Policy Research in Education (CPRE),[56] and the National Partnership for Excellence and Accountability in Teaching (NPEAT)[57]— have produced guidelines for high-quality professional development programs designed to improve student achievement (see box, "Characteristics of Effective Professional Development," on the following page).

The National Commission for Health Education Credentialing (NCHEC) suggests additional standards specifically for the professional development of health educators,[58] and the Harvard Family Research Project addresses preparing teachers in family involvement skills.[59] Policymakers should examine all these sets of recommendations to help guide program design.

Most decisions about professional development are made at the school and district levels. Yet increasingly, states are attempting to influence the scope and intensity of professional development to enhance its quantity and quality through means such as:[60]

- requiring districts and/or schools to engage in a systematic planning process for staff professional development;
- revising recertification requirements;
- providing guidance, technical assistance, incentives— and money— for effective programs based on evidence of success;
- screening and approving providers of professional development services;
- establishing communications networks and facilitating peer-to-peer consultation;
- increasing time requirements for professional development;
- providing more regulatory flexibility for schools to establish their own schedules and calendars;
- deploying teachers and other educators to score state-sponsored tests that call for open-ended responses from students;

Characteristics of Effective Professional Development

There appear to be eight characteristics of effective professional development that can be identified from the findings of recent research and from reports of expert opinion. These eight principles focus attention on professional development strategies for improving students' learning over time.

1. **Professional development should be based on analyses of the differences between (a) actual student performance and (b) goals and standards for student learning.**
2. **Professional development should involve teachers in the identification of what they need to learn and in the development of the learning experiences in which they will be involved.**
3. **Professional development should be primarily school-based and built into the day-to-day work of teaching.**
4. **Professional development should be organized around collaborative problem solving.**
5. **Professional development should be continuous and ongoing, involving follow-up and support for further learning—including support from sources external to the school that can provide necessary resources and new perspectives.**
6. **Professional development should incorporate evaluation of multiple sources of information on (a) outcomes for students and (b) the instruction and other processes that are involved in implementing the lessons learned through professional development.**
7. **Professional development should provide opportunities to gain an understanding of the theory underlying the knowledge and skills being learned.**
8. **Professional development should be connected to a comprehensive change process focused on improving student learning.**

NPEAT recognizes the tension that exists among some of the principles. That is a necessary, perhaps even useful, part of the change process. Our claim is that professional development is more likely to result in substantive and lasting changes in the knowledge, skills, and behaviors of educators that enhance student learning when it includes these characteristics.

—National Partnership for Excellence and Accountability in Teaching[57]

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- sponsoring statewide higher education partnerships for professional development; and
- establishing "master teacher" programs.

Nonteaching school health program staff

Many states offer certification for other positions within a school health program, such as for school nurses, food service directors, athletic coaches, school counselors, psychologists, other pupil support staff, and other school health professionals.

States vary widely in whether they offer certification and in whether certification is required for employment. For example, 32 states offer certification for school nurses, but only 21 require it for employment.[18] Ten states offer certification for school-level food service directors, but only three require it for employment.[61] Every state should establish certification requirements for all positions of responsibility that require professional preparation.

Planning for staff professional development should not overlook the needs of noninstructional staff to receive opportunities for self-improvement. In addition to employed school and district staff, lay members of school boards and school health councils also might benefit from organized programs of orientation training. Finally, students who are involved in peer-to-peer education programs need ongoing training and support.

Interprofessional Education

Interprofessional education is a new trend in preparing human service professionals. Schools of nursing, social work, and other disciplines join with schools of education to prepare teachers and other professionals working with children and families. The purpose of this strategy is to train a range of human service professionals to work more closely with one another, to work in an increasingly collaborative environment, and to deliver services more effectively to families by placing them at the center of the human service system....

Comprehensive interprofessional training programs have the potential to prepare teachers and other human service professionals to work effectively with families. For example, teachers involved in such training programs will be better prepared to identify children's and families' nonacademic support needs and refer them to appropriate outside agencies and personnel. Promising models are currently being developed at Ohio State University, the University of Washington in Seattle, and Miami University in Ohio.

—Harvard Family Research Project[55]

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Resources

- The **University of Kentucky's** website includes links to nearly all states' certification requirements at www.uky.edu/Education/TEP/usacert.html.

- The **American Association for Health Education** (AAHE) has standards for preparation of elementary teachers in health education and preparation of middle school generalists in health education, which were developed in collaboration with several other professional societies. Call (800) 321-0789 or go to www.aahperd.org/aahe.

- The **National Council for Accreditation of Teacher Education** (NCATE) is the professional accrediting organization for graduate schools and colleges of education in the United States. Call (202) 466-7496 or go to www.ncate.org.

- Information about the **National Board for Professional Teaching Standards** (NBPTS) can be found at www.nbpts.org or by calling (800) 22-TEACH.

- *A Competency-Based Framework for Professional Development of Certified Health Education Specialists* is available from the **National Commission for Health Education Credentialing** (NCHEC). Call (888) 673-5445.

- The **Consortium for Policy Research in Education** (CPRE) offers a useful framework for reviewing professional development policies and practices in *Helping Teachers Teach Well: Transforming Professional Development* (June 1995). Go to www.ed.gov/pubs/CPRE/t61/framwork.html.

References

[1] Chervin, D. and Northrop, D., *Education and Health: Partners in Reform*, BellSouth Foundation and the Education Development Center, 1994.

[2] Wolford-Symons, C. et al., "Bridging student health risks and academic achievement through comprehensive school health programs," *Journal of School Health*, 1997; 67(6): 220–227.

[3] NASBE Healthy Schools Network, "Healthy Schools," unpublished vision statement, 1991.

[4] Centers for Disease Control and Prevention, Division of Adolescent and School Health, "Assessing Health-risk Behaviors Among Young People: The Youth Risk Behavior Surveillance System At-a-Glance," 1999.

[5] Centers for Disease Control and Prevention, "Youth risk behavior surveillance— United States, 1997," *MMWR*. August 14, 1998; Vol. 47, No. SS-3.

[6] Vermont Department of Education, "Joint statement on school health," 1995.

[7] Tyson, H., "A load off the teachers' backs: Coordinated school health programs," Kappan Special Report, *Phi Delta Kappan*, January 1999.

[8] The Committee on Comprehensive School Health Programs in Grades K-12, Institute of Medicine, *Schools and Health: Our Nation's Investment*, National Academy Press, 1997: p. 5-1.

[9] New Mexico Department of Education, "Report card of school health programs," 1991.

[10] CDC Division of Adolescent and School Health, "A coordinated school health program: The CDC eight component model of school health programs" (undated). Online at www.cdc.gov/nccdphp/dash/cshpdef.htm.

[11] Wellness Councils of America and Canada, "Why wellness works," undated. Available at www.welcoa.org.

[12] Pittman, K. and Cahill, M., "Pushing the boundaries of education: The implications of a youth development approach to education policies, structures, and collaborations," Academy for Educational Development, July 1992.

[13] Catalano, R. et al., "Positive youth development in the United States: Research findings on evaluations of positive youth development programs," submitted to the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services and the National Institute for Child Health and Human Development, November 1998. Available at http://aspe.os.dhhs.gov/hsp/PositiveYouthDev99/index.htm.

[14] Carnegie Corporation of New York, *Great Transitions: Preparing Adolescents for a New Century*, 1995, p. 2. An abridged version is online at www.carnegie.org/reports/great_transitions/gr_intro.html.

[15] Cotton, K., "Affective and social benefits of small-scale schooling," ERIC Clearinghouse on Rural Education and Small Schools, Number RC 020 835. Available at www.ael.org/small.htm.

[16] National Association of State Boards of Education, *The Future Is Now: Addressing Social Issues in Schools of the 21st Century*, National Association of State Boards of Education, 1999.

[17] Committee on School Health, *School Health: Policy and Practice*, Nader, P., ed., American Academy of Pediatrics, 1993, p. 9–13.

[18] Leavy Small, M. et al., "School health services," *Journal of School Health*, 1995; 65(8): 320.

[19] The Robert Wood Johnson Foundation, *Making the Grade's 1996 Survey of State School-Based Health Center Initiatives*.

[20] Davis, M. et al., *A Closer Look: A Report of Select Findings from the National School Health Survey 1993–94*, University of Colorado Health Sciences Center, 1995.

[21] The Robert Wood Johnson Foundation, *1998 National Survey of State School-Based Health Centers Initiatives*. Highlights are available at www.gwu.edu/~mtg.

[22] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*, 1999.

[23] Adelman, H., "School counseling, psychological, and social services," *Health Is Academic: A Guide to Coordinated School Health Programs*, Marx and Wooley, eds., Teacher's College Press, 1998.

[24] Blum, R., *Reducing the Risk: Connections That Make a Difference in the Lives of Youth*, University of Minnesota. For more information go to www.cpc.unc.edu/addhealth.

[25] National Center for Education Statistics, "Parents' reports of school practices to involve families," *Statistics in Brief*, U.S. Department of Education, Office of Educational Research and Improvement, NCES 97-32, October 1996.

[26] Allensworth, D. et al., *Healthy Students 2000: An Agenda for Continuous Improvement in America's Schools*, American School Health Association, 1994.

[27] National PTA, *National Standards for Parent/Family Involvement Programs*, 1997. An online guide can be found at www.pta.org/programs/stnrdgd.htm.

[28] Beardmore, D., "Are School Health Programs a Burden?" *NASBE Commentaries*, 1996; 2(4).

[29] Dryfoos, J., Presentation to the American Youth Policy Forum, Washington, DC, June 12, 1998. Her research findings can be found in Dryfoos, J., *Safe Passage: Making It Through Adolescence in a Risky Society: What Parents, Schools, and Communities Can Do*, Oxford University Press, 1998.

[30] Kentucky Department of Education, "Program brief: Family Resource/Youth Services Centers," July 1996.

[31] American Education Research Association (AERA) and U.S. Department of Education, *School-Linked Comprehensive Services for Children and Families: What We Know and What We Need to Know*, 1995. Available online at www.ed.gov/pubs/Compre/index.html.

[32] Resnicow, K. and Allensworth, D., "Conducting a comprehensive school health program," *Journal of School Health*, 1996; 66(2): 59-63.

[33] Butler, T., "Delaware school health advisory committee," *Journal of School Health*, 1995;65(2):60-62; and Arbeit, M. et al., "The implementation of a cardiovascular school health promotion program: Utilization and effect of a school health advisory committee: The Heart Smart program," *Health Education Research*, 1991;6(4):423-430.

[34] Collins, J. et al., "School health education," *Journal of School Health*, October 1995, Vol. 65, No. 8, p. 306-307.

[35] Adapted from the *ASTHO Report* of the Association of State and Territorial Health Officials, January–February 1998, page 4.

[36] Student Services/Prevention Wellness Team, *Wisconsin's Framework for Comprehensive School Health Programs*, Wisconsin Department of Public Instruction, 1997.

[37] National Association of State Boards of Education, "Financing school-based health and social services programs," *NASBE Policy Update*, February 1999.

[38] Education Commission of the States, *State Education Leader*, Denver, CO, 1994; 13: 2.

[39] Olson, L., "In survey, U.S. adults rank academics below health information, work skills," *Education Week*, February 17, 1999, Vol. 18, number 23, page 5. The full report is online at www.mcrel.org/survey.

[40] Hawkins, J.D. et al., "Preventing adolescent health-risk behaviors by strengthening protection during childhood," *Archives of Pediatric and Adolescent Medicine*, 1999; 153(3): 226-234.

[41] West Virginia Department of Education, "How health education links with other education goals," 1997.

[42] NASBE count.

[43] American Cancer Society, *Health for Success: The National Health Education Standards*, 1995. Available at www.cancer.org.

[44] North Carolina Department of Education, *Framework for Healthful Living Education*, 1996.

[45] Texas Education Code, §28.002; Chapter 115. Texas Essential Knowledge and Skills for Education; Subchapter A. Elementary; §115.2. Health Education, Kindergarten, (a)(1).

[46] National Association of State Boards of Education, *Teaching Policy Briefs*, 1992.

[47] National Commission on Teaching & America's Future, *What Matters Most: Teaching for America's Future*, 1996.

[48] American Association of Health Education, "NCATE program standards: Initial programs in health education," revised September 1995.

[49] National Association for Sport and Physical Education, "NCATE program standards: initial and advanced programs in physical education," revised January 1997.

[50] National Association of School Psychologists, "NCATE program standards: masters, post-masters, specialist, and doctoral programs in school psychology," revised September 1994.

[51] Elementary Program Standards Development Drafting Committee, "Program standards for elementary teacher preparation," National Council for Accreditation of Teacher Education, Draft November 29, 1999. Available on the Internet at www.ncate.org/projects/npt/elemdraft/elemstds.PDF.

[52] Collins, J., et al., "School health education," *Journal of School Health*, 1995; 65(8): 305.

[53] Pate, R., et al., "School physical education," *Journal of School Health*, 1995; 65(8): 317.

[54] U.S. Department of Education, "Building bridges: The mission and principles of professional development," June 1996.

[55] National Staff Development Council, "NSDC standards for staff development," undated, at www.nsdc.org/standards.htm.

[56] Corcoran, T., "Helping teachers teach well: Transforming professional development," Consortium for Policy Research in Education (CPRE), June 1995.

[57] National Partnership for Excellence and Accountability in Teaching, "Characteristics of effective professional development," undated, at www.npeat.org/dialogue.htm.

[58] National Commission for Health Education Credentialing, *A Competency-Based Framework for Professional Development of Certified Health Education Specialists*, 1996.

[59] Shartrand, A. et al., "New skills for new schools: Preparing teachers in family involvement," Harvard Family Research Project, Harvard Graduate School of Education, 1997.

[60] Education Commission of the States, *Standards and Education: A Roadmap for State Policymakers*, 1996: 28–29.

[61] Pateman, B. et al., "School food service," *Journal of School Health*, 1995; 65(8): 327–332.

D. Policies to Encourage Physical Activity

Schools can and do play a powerful role in influencing students' physical activity behaviors. Challenging physical education and health education classes give students the knowledge, motivation, and skills needed for lifelong physical activity. In addition, schools provide multiple opportunities for students to practice physical activity through participation in physical education class, recess, intramural programs, sports and recreation clubs, interscholastic athletics, and links with community-based sports and recreation programs.

This chapter provides guidance on developing a comprehensive, integrated policy aimed at promoting lifelong physical activity among children, adolescents, and school staff. The sample policy in this chapter addresses all aspects of the school setting that influence a person's physical activity patterns. The policy:

- defines the purpose and goals of physical activity programs;
- offers principles to direct the physical education program, extracurricular physical activity programs, and other school-based opportunities for physical activity; and
- establishes safety guidelines for physical activity programs.

A Broad and Firm Foundation

In the great work of education, our physical condition, if not the first step in point of importance, is the first in order of time. On the broad and firm foundation of health alone can the loftiest and most enduring structures of the intellect be reared.

—Horace Mann

The sample physical activity policy incorporates statements of recommended practice. What is reasonable, feasible, and acceptable in a given state, school district, or school depends on local circumstances and the results of the policymaking process.

Adopting sound policy is just a start. A comprehensive policy is more likely to be smoothly implemented and consistently enforced if it receives strong administrative support, and if all staff, not just physical education teachers, receive an orientation that describes the policy and the rationale behind it. These actions can increase the importance with which staff view physical activity issues and encourage them to promote a physically active lifestyle in their interactions with students.

The sample physical activity policy is divided into five parts, as listed on the following page. A discussion section that provides supportive information and a concise list of key resources follow each part of the policy.

Chapter contents

1. Purpose and Goals D-3
2. Physical Education D-11
3. Extracurricular Physical Activity Programs D-23
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1. Purpose and Goals

A strong statement of purpose and goals provides a firm foundation for a sound policy. It justifies the policy to staff and the public, communicates policymakers' priorities, and helps guide program implementation.

Physical Activity Sample Policy, Part One:

INTENT. Every student shall be physically educated—that is, shall develop the knowledge and skills necessary to perform a variety of physical activities, maintain physical fitness, regularly participate in physical activity, understand the short- and long-term benefits of physical activity, and value and enjoy physical activity as an ongoing part of a healthful lifestyle. In addition, staff are encouraged to participate in and model physical activity as a valuable part of daily life.

School leaders shall develop and implement a comprehensive plan to encourage physical activity that includes the following:

- a sequential program of physical education that involves moderate to vigorous physical activity on a daily basis; teaches knowledge, motor skills, self-management skills, and positive attitudes; promotes activities and sports that students enjoy and can pursue throughout their lives; is taught by well-prepared and well-supported staff; and is coordinated with the health education curriculum;
- time in the elementary school day for supervised recess;
- opportunities and encouragement for students to voluntarily participate in before- and after-school physical activity programs, such as intramurals, clubs, and, at the high school level, interscholastic athletics;
- joint school and community recreation activities;
- opportunities and encouragement for staff to be physically active; and
- strategies to involve family members in program development and implementation.

The program shall make effective use of school and community resources and equitably serve the needs and interests of all students and staff, taking into consideration differences of gender, cultural norms, physical and cognitive abilities, and fitness levels.

RATIONALE. Schools have a responsibility to help students and staff establish and maintain lifelong habits of being physically active. According to the U.S. Surgeon General, regular physical activity is one of the most important things people can do to maintain and improve their physical health, mental health, and overall well-being. Regular physical activity reduces the risk of premature death in general and of heart disease, high blood pressure, colon cancer, and diabetes in particular. Promoting a physically active lifestyle among young people is important because:

- through its effects on mental health, physical activity can help increase students' capacity for learning;
- physical activity has substantial health benefits for children and adolescents, including favorable effects on endurance capacity, muscular strength, body weight, and blood pressure; and
- positive experiences with physical activity at a young age help lay the basis for being regularly active throughout life.

DEFINITIONS. For the purposes of this policy:

"Extracurricular activities" refers to school-sponsored voluntary programs that supplement regular education and contribute to the educational objectives of the school.

"Health-related physical fitness" refers to cardiorespiratory endurance, muscular strength and endurance, flexibility, and body composition.

"Interscholastic athletics" refers to organized individual and team sports that involve more than one school.

"Intramurals" refers to physical activity programs that provide opportunities for all students to participate in sport, fitness, and recreational activities within their own school.

"Moderate physical activities" refers to activities that are equivalent in intensity to brisk walking.

"Physical education" refers to a planned, sequential program of curricula and instruction that helps students develop the knowledge, attitudes, motor skills, self-management skills, and confidence needed to adopt and maintain physically active lifestyles.

"Recess" refers to regularly scheduled periods within the school day for unstructured physical activity and play.

"Regular physical activity" refers to participation in moderate to vigorous physical activity for at least 30 minutes per day on most, if not all, days of the week.

"Skill-related physical fitness" refers to balance, agility, power, reaction time, speed, and coordination.

"Vigorous physical activity" refers to exertion that makes a person sweat and breathe hard, such as basketball, soccer, running, swimming laps, fast bicycling, fast dancing, and similar aerobic activities.

Discussion

Schools should play an active role in promoting physical activity for three important reasons:

1. Increasing students' capacity for learning

Throughout human history— in ancient China, India, Africa, the Americas, ancient Greece, and Western civilization— people have recognized that strong bodies and strong minds go together.[2] Although research has not been conducted that conclusively demonstrates a direct link between physical activity and improved academic performance, such a link can be inferred. Studies among adolescents find that physical activity is consistently related to higher self-esteem and to less anxiety and stress.[3] These benefits are likely to have a positive effect on student achievement.

Physical Education and Learning

In the same way that exercise shapes up the muscles, heart, lungs, and bones, it also strengthens the basal ganglia, cerebellum, and corpus callosum, all key areas of the brain. We know exercise fuels the brain with oxygen, but it also feeds it neurotropins (high-energy food) to enhance growth and greater connections between neurons. Aerobic conditioning also has been known to assist in memory.

—Eric Jensen[5]

To Do Their Best

From the time of the ancient Greeks and the early Chinese philosophers, educators have recognized that children and youth need physical activity as well as mental pursuits to do their best. Physical education has long been part of the K–12 school curriculum in the United States because of the belief that physical activity is essential for healthy growth and development.

—Vernon Seefeldt[1]

In addition, analysis of a national survey of high school students found that low levels of physical activity were associated with high-risk behaviors such as cigarette smoking and marijuana use.[4]

2. Promoting good physical health and development during childhood and adolescence

Regular physical activity offers young people many health benefits,[2,3] including the following:

- improves aerobic endurance and muscular strength;
- helps control weight, build lean muscle, and reduce fat;
- helps build greater bone mass, which may help prevent osteoporosis in adulthood;

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Crisis Proportions

No [health] problem needs our attention more than the growing epidemic of obesity in America. In sheer numbers and its toll in death and disability, obesity has reached crisis proportions in the United States.

—Dr. C. Everett Koop[9]

- helps build and maintain healthy joints;
- prevents or delays the development of high blood pressure;
- helps reduce blood pressure in some adolescents with hypertension; and
- may favorably affect blood lipid profiles.

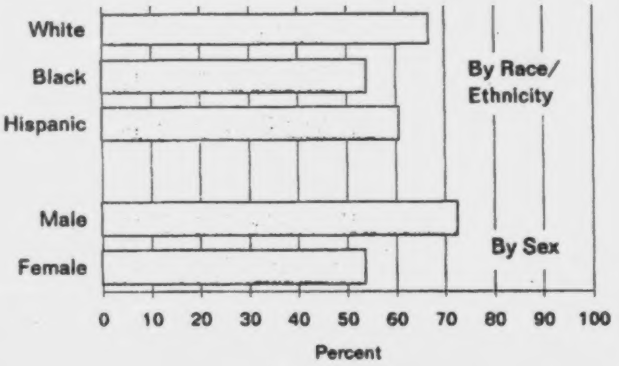
Inadequate participation in physical activity is presumed to be a major contributor to the "epidemic of obesity" that has plagued the nation's young people during the past two decades. The percentage of young people who are overweight in the United States— 14 percent of children ages 6-11 and 12 percent of adolescents ages 12-17— has more than doubled in the past 30 years.[6]

Obesity in young persons is related to elevated blood cholesterol levels, high blood pressure, psychological stress, and increased adult mortality.[3] Increasing rates of obesity might be contributing to the sharp increase in the number of cases of Type 2 diabetes (commonly known as "adult-onset" diabetes) among young people that doctors have reported in recent years.[7,8] Increasing the physical activity levels of young people is key to slowing and eventually reversing this epidemic.

Chart 1

Who Is Active?

Percentage of students in grades 9–12 who participated in vigorous physical activity for at least 20 minutes on three or more of the past seven days, by race/ethnicity and sex, 1997.



—Centers for Disease Control and Prevention[10]

3. Preventing premature deaths

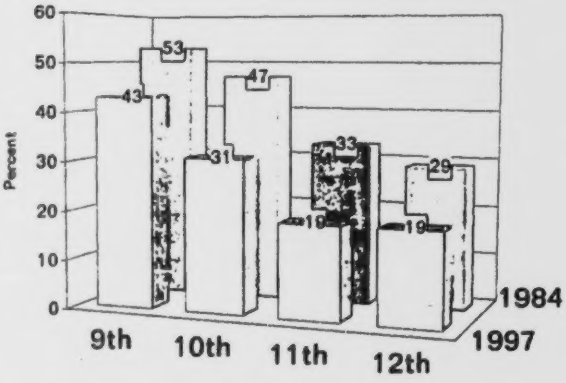
Physical inactivity and a poor diet together account for at least 300,000 deaths among adults in the United States each year— only tobacco use contributes to more deaths.[11] The landmark 1996 report of the Surgeon General, *Physical Activity and Health,*[2] concludes that higher levels of regular physical activity are associated with lower mortality rates for adults and that even those who are moderately active on a regular basis have lower mortality rates than those who are least active. The report documents how regular physical activity reduces the risk of dying from heart disease and of developing diabetes, high blood pressure, and colon cancer.

It is during their youth when people begin to acquire and establish patterns of health-related behaviors that can influence their chances of dying prematurely in adulthood.[3] Indeed, some of the physiological processes that lead to chronic diseases related to lack of physical activity begin in childhood. For example, early indicators of atherosclerosis, the hardening of the arteries that is the most common cause of coronary heart disease, begin in youth.[12]

Chart 2

Physical Activity by Grade

Percentage of students in grades 9–12 who participated in vigorous physical activity for at least 20 minutes on three or more of the past seven days, by sex and grade, 1997.



—Centers for Disease Control and Prevention[10]

Youth activity patterns

Surveys of youth physical activity patterns have found that 1) a substantial proportion of children and adolescents are not sufficiently active; 2) a considerably smaller portion of girls than boys are sufficiently active; 3) African-American and Hispanic high school students are less likely to be active than their white peers; and 4) activity participation declines with age during adolescence[14] (see Chart 1, "Who is Active?" on the preceding page and Chart 2, "Physical Activity by Grade," above). Specifically:

- nearly half of young people aged 12-21 do not engage in vigorous physical activity on a regular basis;[15]

- among high school students, 72 percent of boys but only 54 percent of girls participate in vigorous physical activity on a regular basis, and 58 percent of boys but only 43 percent of girls participate in strengthening exercises on a regular basis.[10] This gender gap is of major

The Importance of Exercise to Young Women

Unique to females is the effect of exercise on reproductive functioning and menarche [the onset of menstruation]. There are many anecdotal reports of more regular menstrual cycles and less physical distress associated with moderate physical activity....

[In addition,] in later life women are especially at risk of osteoporosis. One major advantage of physical activity for girls is that it increases "peak bone mass." Peak bone mass is the level of bone mass at its highest point—usually occurring in the teens or early 20s. High peak bone mass can be viewed much as a bank savings account where withdrawals can be made later in life when needed. The higher the peak mass, the less likely that losses later in life will result in low bone mass or osteoporosis.

—President's Council on Physical Fitness and Sports[13]

Guidelines from CDC

CDC's *Guidelines for School and Community Programs to Promote Lifelong Physical Activity Among Young People* were developed in collaboration with experts from universities and national, federal, and voluntary agencies and organizations. They are based on an in-depth review of research, theory, and current practice in physical education, exercise science, health education, and public health. The guidelines below include recommendations regarding 10 aspects of school and community programs to promote lifelong physical activity among young people. This policy guide is explicitly based on these guidelines:

POLICY: Establish policies that promote enjoyable, lifelong physical activity among young people.

ENVIRONMENT: Provide physical and social environments that encourage and enable safe and enjoyable physical activity.

PHYSICAL EDUCATION: Implement physical education curricula and instruction that emphasize enjoyable participation in physical activity and that help students develop the knowledge, attitudes, motor skills, behavioral skills, and confidence needed to adopt and maintain physically active lifestyles.

HEALTH EDUCATION: Implement health education curricula and instruction that help students develop the knowledge, attitudes, behavioral skills, and confidence needed to adopt and maintain physically active lifestyles.

EXTRACURRICULAR ACTIVITIES: Provide extracurricular physical activity programs that meet the needs and interests of all students.

PARENTAL INVOLVEMENT: Include parents and guardians in physical activity instruction and in extracurricular and community physical activity programs and encourage them to support their children's participation in enjoyable physical activities.

PERSONNEL TRAINING: Provide training for education, coaching, recreation, health care, and other school and community personnel that imparts the knowledge and skills needed to effectively promote enjoyable, lifelong physical activity among young people.

HEALTH SERVICES: Assess physical activity patterns among young people, counsel them about physical activity, refer them to appropriate programs, and advocate for physical activity instruction and programs for young people.

COMMUNITY PROGRAMS: Provide a range of developmentally appropriate community sports and recreation programs that are attractive to all young people.

EVALUATION: Regularly evaluate school and community physical activity instruction, programs, and facilities.

—Centers for Disease Control and Prevention[3]

How Much Physical Activity Is Enough?

For elementary school-aged children:

- [At a minimum,] elementary school-aged children should accumulate at least 30 to 60 minutes of age and developmentally appropriate physical activity from a variety of activities on all, or most, days of the week.
- [Ideally,] an accumulation of more than 60 minutes, and up to several hours per day, of age and developmentally appropriate activity is encouraged for elementary school-aged children.
- Some of the child's activity each day should be in periods lasting 10 to 15 minutes or more and include moderate to vigorous activity. This activity will typically be intermittent in nature, involving alternating moderate to vigorous activity with brief periods of rest and recovery.
- Extended periods of inactivity are inappropriate for children.

—National Association for Sport and Physical Education[16]

For adolescents:

- All adolescents should be physically active daily, or nearly every day, as part of play, games, sports, work, transportation, recreation, physical education, or planned exercise, in the context of family, school, and community activities.
- Adolescents should engage in three or more sessions per week of activities that last 20 minutes or more at a time and that require moderate to vigorous levels of exertion.

—International Consensus Conference on Physical Activity Guidelines for Adolescents[17]

concern because physical activity in youth is particularly critical to two aspects of women's healthy growth and lifelong health: maintaining a fit reproductive system and preventing low bone density and osteoporosis (see box, "The Importance of Exercise to Young Women," on page D-7);

- regular participation in vigorous physical activity has been reported by 69 percent of young people aged 12–13 but by only 38 percent of those aged 18–21;[15] and
- seventy-three percent of ninth graders but only 58 percent of twelfth graders regularly participate in vigorous physical activity (see Chart 2).[10]

Resources

- Your state or local departments of education, public health, and/or recreation might have data to assist in program planning or offer other resources.
- **The National Association of State Boards of Education** (NASBE) and the **National Schools Boards Association** (NSBA) each operate school health resource databases that contain many sample policies. NASBE's database focuses on state-level policies, whereas NSBA has collected a large number of school district policies and support documents. NSBA has compiled excerpts from key documents and sample district policies in a *Physical Activity 101* packet. Both organizations can also provide up-to-date information on policy topics, information on people's experiences in implementing policies, consultation on specific policy issues, and referrals to other experts in the field.
  - Contact NASBE at (703) 684-4000 or boards@nasbe.org.
  - Contact NSBA at (703) 838-6722 or schoolhealth@nsba.org.

- The **CDC Division of Adolescent and School Health** (DASH) offers a variety of support services for schools. The materials and services available include:
    - the *Guidelines for School and Community Programs to Promote Lifelong Physical Activity Among Young People*, which this policy guide is based on;
    - the *School Health Index for Physical Activity and Healthy Eating: A Self-Assessment and Planning Guide*, a companion document to this policy guide that provides a practical, detailed checklist of the elements of exemplary physical activity and nutrition programs that schools and districts can use for self-diagnosis; and
    - assistance in implementing the Youth Risk Behavior Survey (YRBS), a nationwide system for collecting data on youth behaviors. An easy-to-use CD-ROM of national and state summary data is available to examine youth risk behaviors and trends over time in six risk categories.

  Write to: 4770 Buford Highway, NE, Mail Stop K-32, Atlanta, GA 30341-3717;
  telephone: (770) 488-3168;
  FAX: (770) 488-3111;
  e-mail: cdcinfo@cdc.gov; or
  go to www.cdc.gov/nccdphp/dash.

- Another companion book to this policy guide is *Active Youth: Ideas for Implementing CDC's Physical Activity Promotion Guidelines* (1998). It explains CDC's guidelines in clear terms and provides detailed descriptions of 20 successful physical activity programs across the country that represent a wide range of settings and target audiences. It is available from **Human Kinetics** at (800) 747-4457 or go to www.humankinetics.com.

- The 1996 **U.S. Surgeon General's** report, *Physical Activity and Health*, summarizes a tremendous amount of scientific research and makes specific recommendations. The document is available from the U.S. Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954 (#S/N 017-023-00196-5), or go to www.cdc.gov/nccdphp/sgr/contents.htm.

- *Physical Activity and Sport in the Lives of Girls: Physical and Mental Health Dimensions from an Interdisciplinary Approach* (1997) is a report of the **President's Council on Physical Fitness and Sports**. Call (202) 690-9000 to order.

  The President's Council has also sponsored series of in-depth *Research Digests* on additional topics that are available on the Internet at www.indiana.edu/~preschal/digests/digest.html.

- The **American Heart Association** has information and advice on physical activity in daily life. Contact your local chapter, call the national office at (800) AHA-USA1, or go to www.americanheart.org.

- The **American Cancer Society** has information on how physical activity can help prevent cancer. Call (800) ACS-2345 or go to www.cancer.org.

Note

The organizations included as resources in this guide offer a broad range of assistance, have a national scope, are easily accessed, have materials available at low or no cost, and/or have specialized expertise. The lists are not exhaustive. Scores of other organizations provide high-quality assistance and advice to educators; hundreds of informative books and articles are also available. Consider the resources listed here as starting points.

2. Physical Education

A sound policy on physical education emphasizes that physical education is an essential part of every student's preparation for adult life. The physical education program needs to be consistent with national standards and foster habits of lifelong, enjoyable physical activity.

Physical Activity Sample Policy, Part Two:

ALL STUDENTS ENROLLED. Every student in each grade, pre-kindergarten through twelfth, shall participate in daily physical education for the entire school year, including students with disabling conditions and those in alternative education programs. Students in the elementary grades shall participate in physical education for at least 150 minutes during each school week, and students in middle schools and high schools shall participate for at least 225 minutes per week.

INSTRUCTIONAL PROGRAM DESIGN. Schools shall establish specific learning goals and objectives for physical education. A sequential, developmentally appropriate curriculum shall be designed, implemented, and evaluated to help students develop the knowledge, motor skills, self-management skills, attitudes, and confidence needed to adopt and maintain physical activity throughout their lives. The physical education program shall:

1. emphasize knowledge and skills for a lifetime of regular physical activity;
2. be consistent with *state/district's* *standards/guidelines/framework* for physical education and with national standards that define what students should know and be able to do;
3. devote at least 50 percent of class time to actual physical activity in each week, with as much time as possible spent in moderate to vigorous physical activity;
4. provide many different physical activity choices;
5. feature cooperative as well as competitive games;
6. meet the needs of all students, especially those who are not athletically gifted;
7. take into account gender and cultural differences in students' interests;
8. teach self-management skills as well as movement skills;

9. actively teach cooperation, fair play, and responsible participation in physical activity;

10. have student/teacher ratios comparable to those in other curricular areas;

11. promote participation in physical activity outside of school;

12. focus, at the high school level, on helping adolescents make the transition to an active adult lifestyle; and

13. be an enjoyable experience for students.

Teachers shall aim to develop students' self-confidence and maintain a safe psychological environment free of embarrassment, humiliation, shaming, taunting, or harassment of any kind. Physical education staff shall not order performance of physical activity as a form of discipline or punishment.

Suitably adapted physical education shall be included as part of individual education plans for students with chronic health problems, other disabling conditions, or other special needs that preclude such students' participation in regular physical education instruction or activities.

ASSESSMENT. All students shall be regularly assessed for attainment of the physical education learning objectives. Course grades shall be awarded in the same way grades are awarded in other subject areas and shall be included in calculations of grade point average, class rank, and academic recognition programs such as honor roll.

HEALTH-RELATED FITNESS TESTING. Health-related physical fitness testing shall be integrated into the curriculum as an instructional tool, except in the early elementary grades. Tests shall be appropriate to students' developmental levels and physical abilities. Such testing shall be used to teach students how to assess their fitness levels, set goals for improvement, and monitor progress in reaching their goals. Staff will maintain the confidentiality of fitness test results, which will be made available only to students and their parents/guardians.

As health-related physical fitness is influenced by factors beyond the control of students and teachers (such as genetics, physical maturation, disabling conditions, and body composition), test results shall not be used to determine course grades or to assess the performance of individual teachers.

EXEMPTIONS. Physical education teaches students essential knowledge and skills; for this reason, exemptions from physical education courses shall not be permitted on the basis of participation on an athletic team, community recreation program, ROTC, marching band, or other school or community activity. A student may be excused from participation in physical education only if: 1) a physician states in writing that specific physical activities will jeopardize the student's health and well-being or 2) a parent/guardian requests exemption from specific physical activities on religious grounds.

TEACHING STAFF. Physical education shall be taught by well-prepared specialists who are certified by the state to teach physical education. All physical education teachers shall be adequately prepared and regularly participate in professional development activities to effectively deliver the physical education program. Preparation and professional development activities shall provide basic knowledge of the physical development of children and adolescents combined with skill practice in program-specific activities and other appropriate instructional techniques and strategies designed to promote lifelong habits of physical activity.

ADEQUATE FACILITIES. School leaders shall endeavor to ensure the cost-efficient provision of adequate spaces, facilities, equipment, supplies, and operational budgets that are necessary to achieve the objectives of the physical education program.

School authorities shall minimize the use of physical education facilities for noninstructional purposes, such as using the gymnasium for school assemblies during times scheduled for physical education classes.

EDUCATIONAL REINFORCEMENT. The physical education program shall be closely coordinated with the other components of the overall school health program. Physical education topics shall be integrated within other curricular areas. In particular, the benefits of being physically active shall be linked with instruction about human growth, development, and physiology in science classes and with instruction about personal health behaviors in health education class.

The physical education program shall actively engage families as partners in their children's education and collaborate with community agencies and organizations to provide ample opportunities for students to participate in physical activity beyond the school day.

Discussion

Physical education is an integral part of the total education of a child. Well-planned, well-implemented physical education programs can provide many important benefits for young people (see box, "Why Children Need Physical Education," on the next page). A good physical education program includes:

- instruction about how physical activity improves personal health and well-being;

Why Children Need Physical Education

Benefits of well-planned, well-implemented physical education programs include:

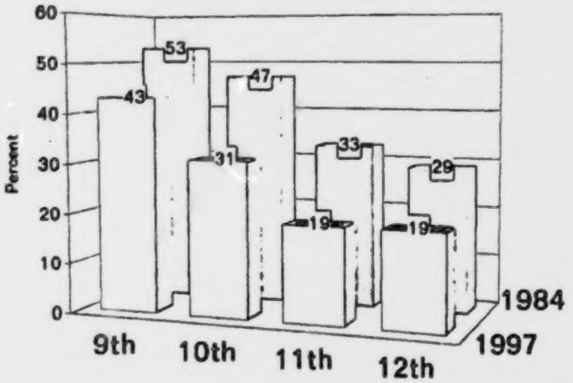
- **IMPROVED PHYSICAL FITNESS: Improves children's muscular strength, flexibility, muscular endurance, body composition, and cardiovascular endurance.**
- **REINFORCES KNOWLEDGE LEARNED IN OTHER SUBJECT AREAS: Serves as lab for application of content from science, math, and social studies courses.**
- **SELF-DISCIPLINE: Facilitates development of student responsibility for health and fitness.**
- **SKILL DEVELOPMENT: Develops motor skills that allow for safe, successful, and satisfying participation in physical activities.**
- **EXPERIENCE SETTING GOALS: Gives children the opportunity to set and strive for personal, achievable goals.**
- **IMPROVED JUDGMENT: Influences moral development by providing students with opportunities to assume leadership, cooperate with others, and accept responsibility for their own behavior.**
- **IMPROVED SELF-CONFIDENCE AND SELF-ESTEEM: Helps children become more confident, assertive, independent, and self-controlled.**
- **STRESS REDUCTION: Provides an outlet for releasing tension and anxiety.**
- **STRENGTHENS PEER RELATIONSHIPS: Helps children socialize with others more successfully.**

—National Association for Sport and Physical Education[15]

Chart 3

Declining Participation

Percentage of students in grades 9–12 who attended physical education class every day in an average week, 1984 and 1997, by grade.



—Centers for Disease Control and Prevention[16,17]

- aerobic activities designed to improve cardiovascular fitness on most, if not all, days of the week;
- activities designed to improve strength and flexibility on three to four days of the week;
- development of motor skills through instruction in a variety of movement forms, such as specific sports, dance, gymnastics, and aquatics; and
- development of self-management skills, such as self-monitoring, self-evaluation, and self-reinforcement.

Daily physical education

Physical education needs to be offered every day to adequately address the necessary instructional components and provide opportunities for

State or Local?

In its work with state education policymakers, NASBE recommends that minimum time requirements and student/teacher ratios should be local decisions and should not be decided at the state level. Today's education reform movement is based on the principle that states should focus on establishing education goals and defining the results expected of students and schools, and then allow local schools and districts the flexibility to determine for themselves the best means of reaching those goals. Every state must determine for itself, through state law and the policymaking process, the most appropriate policy levels at which to establish physical education program requirements.

adequate practice and health-enhancing physical activity. Yet participation in daily physical education has dropped precipitously in recent years, from 42 percent of high school students in 1991 to only 27 percent in 1997.[20]

A 1994 national survey found that only 17 percent of middle/junior high schools and two percent of high schools required physical education five days per week each year.[21,22] As of 1997, 47 states and nearly all local school districts required *some* physical education, but Illinois is the only state that currently requires *daily* physical education in every grade K–12.[23] Chart 3, "Declining Participation" (on the preceding page), illustrates how attendance in daily physical education declines dramatically as students pass through high school and how attendance has declined substantially over time.

Physical education sessions for elementary school children should last at least 30 minutes and sessions for middle and high school students should last at least 45 minutes. Recognizing that schools that use block scheduling might not be able to offer physical education on a daily basis, the National Association for Sport and Physical Education (NASPE) recommends minimum weekly amounts of instructional time: 150 minutes for elementary school students and 225 minutes for middle and high school students. Schools should not meet this target by counting time students spend in unstructured free-play activities such as recess.

Physical education standards

At least 28 states have developed standards and/or curriculum frameworks for physical education. Some states have directly based their standards or frameworks on the national standards for physical education produced by NASPE. The standards, which should form the foundation of any physical education program, are intended to help students become "a physically educated person."

Today's state-of-the-art physical education program is considerably different than the physical education that most of today's adults experienced in school. Although traditional physical education classes stressed the knowledge and skills needed to excel in competitive sports, today's exemplary programs emphasize teaching the types of knowledge and skills necessary for a lifetime of regular physical activity. The "new physical education":

- is based on national standards— just like other academic subjects— that define what students should know and be able to do as well as the levels of achievement that students are expected to attain;

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National Standards for Physical Education

A physically educated person...

- Demonstrates competency in many movement forms and proficiency in a few movement forms.
- Applies movement concepts and principles to the learning and development of motor skills.
- Exhibits a physically active lifestyle.
- Achieves and maintains a health-enhancing level of physical fitness.
- Demonstrates responsible personal and social behavior in physical activity settings.
- Demonstrates understanding and respect for differences among people in physical activity settings.
- Understands that physical activity provides opportunities for enjoyment, challenge, self-expression, and social interaction.

—National Association for Sport and Physical Education[24]

- provides students with physical activity choices so they can select activities that appeal to them;
- features cooperative as well as competitive activities;
- meets the needs of all students, especially those who are not athletically gifted;

- provides students with physical activity choices so they can select activities that appeal to them;
- features cooperative as well as competitive activities;
- meets the needs of all students, especially those who are not athletically gifted;

- develops in all students self-confidence in their physical activity abilities;

Suggested Instructional Themes in Physical Education

- Physical, social, and mental health benefits of lifelong physical activity and physical fitness;
- development of motor skills;
- competency in movement forms;
- components of health-related fitness;
- phases of a workout;
- how much physical activity is enough;
- safe and unsafe weight management and conditioning practices;
- balancing food intake and physical activity;
- personal assessment of one's own health-related fitness;
- development of safe and effective personal activity plans;
- monitoring progress toward achieving personal activity goals;
- social aspects of physical activity, including practicing responsible behaviors;
- overcoming barriers to physical activity;
- how to find valid information or services related to physical activity and fitness;
- opportunities for physical activity in the community;
- dangers of using performance-enhancing drugs such as steroids;
- weather-related safety; and
- disease and injury prevention and proper emergency response.

- eliminates practices that humiliate students, such as having student captains choose team members;
- assesses students on their progress in reaching personal physical activity and fitness goals and not on whether they meet an absolute standard;

- uses strategies to keep students active for a large part of class time (e.g., not playing games of elimination, reducing time spent waiting in line to use equipment);
- teaches self-management skills to help students learn how to overcome barriers to physical activity during childhood and adulthood; and
- makes physical education an enjoyable experience for students.

Unfortunately, a 1994 nationwide survey found that traditional sports activities still tend to dominate physical education classes and teacher training programs.[26] This is not to say that competitive team sports do not belong in a sound physical education program: what matters is *how* the sports are organized and taught. California's *Physical Education Framework* document helps to explain the new instructional approach (see box, "Clearing up Misunderstandings").

Clearing up Misunderstandings

Myth—Physical education is intended to help students achieve excellence in games and sports.

Framework vision—Physical education is a multi-faceted process that teaches a wide range of skills and activities with the aim of the students becoming physically educated, physically fit, able to enjoy a variety of physical activities, and committed to lifelong health and physical well-being. It is a continuing process of articulated, sequential development of skills, talents, attitudes, and behaviors.

Myth—Physical education is not an integral part of the school's curriculum. It is a frill.

Framework vision—Physical education is closely connected to and supports the other disciplines. Physical education is an integral component of the school curriculum. It involves students directly in thinking, creating meaning, and learning how to learn.

Myth—Physical education focuses on the more athletically gifted.

Framework vision—All children have the potential to become physically educated, and an effective physical education program will reach all children regardless of their talents, skills, or limitations.

Myth—Physical education should be similar to training: highly skill- and drill-oriented. It should be mainly a mechanical process.

Framework vision—In physical education emphasis must be placed on a broad spectrum of learning and personal development. Learning involves thinking and feeling, being active and processing information, not just using skills. Education encompasses much more than training.

Myth—Children should carry out a variety of physical fitness activities but do not need to understand why they are doing so.

Framework vision—Learning cognitively is as important to physical education as learning specific movement skills. Students need to know why they are learning skills in physical education and how they are benefiting personally. Then they will be more likely to accept responsibility for improving skills on their own and enjoying the benefits of physical education over the long term.

Myth—Because there are always winners and losers in games and sports, physical education must emphasize competition to prepare children for participation in the real world.

Framework vision—Although teachers are aware of the nature of competition, they do not require higher levels of competition from children before they are ready. Further, competition can take different forms. Activities in physical education may emphasize self-improvement, participation, and cooperation instead of winning or losing.

—California Department of Education[25]

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In the News

Fun Physical Education Classes Lead to Active Kids

Kids who enjoy gym class are more likely to have physically active lives outside of school than those who dread P.E., according to a report in *Health Psychology*.[28]

Children are also more likely to exercise if their free time in the afternoon is spent outdoors or playing sports, and if their family encourages physical activity.

"This is the first national study to examine the explanations for why some kids are exercising, and some kids are not," said lead author James Sallis, a psychology professor at San Diego State University....

Sallis and his colleagues interviewed 1,504 pairs of parents and children in grades four through twelve. They looked at a number of potential factors, such as time barriers, fees for activity, and body mass index, a calculated number that compares weight to height.

Only three factors—enjoying gym class, afternoon activities, and family support of physical activity—consistently influenced both sexes and all age groups.

—Reuters Health News[29]

Eliminating Humiliation

At Crimson Elementary School in Mesa, Arizona, physical education teacher James Roberts tries to minimize the polarization between natural athletes and students who struggle with athletic skills. Relays, where youngsters spend 80 percent of the time waiting for their turn and have the opportunity to make fun of awkward children, have been eliminated. So has the often humiliating practice of "picking" team members.

—The Washington Post[30]

Rationale Statement for Physical Activity Standards

A wealth of information has been accumulated to point to the importance of physical activity in promoting health and wellness. Evidence also indicates that habits (lifestyles) established in youth are likely to influence adult lifestyles and associated health and wellness. Physical activity, a primary [protective] factor for many chronic health conditions, is an integral part of comprehensive school health education but also must be promoted as an important educational goal. Meeting physical activity standards includes both promotion of physical activity among youth and promotion of lifelong physical activity that will enhance workplace skills, fitness, and wellness associated with quality of life. Achieving lifetime physical activity standards results in learning real life skills. Higher-order skills include decision making and problem solving required to become informed, lifetime physical activity consumers.

—Arizona Department of Education[27]

The resources listed at the end of this section point to professional associations that can provide practical guidance on successfully implementing proven strategies and methods that reflect the lifelong health approach to physical education.

Program design

Physical education classes typically devote much less than half of class time to physical activity, with considerable amounts of time spent on administrative tasks and waiting for a turn at an activity.[31,32,33] A 1997 national survey found that, among high school students enrolled in physical education, only 74 percent reported being physically active for 20 minutes or more in an average class.[10]

Studies have found that improved curriculum and teacher professional development can substantially increase the time spent by students on moderate to vigorous physical activity in class and that the target of 50 percent of time spent in activity is feasible.[34]

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Avoiding Failure

We never put kids in situations where they'll fail and won't want to remain active. We want all students to have the knowledge and skills to engage in a physically active lifestyle throughout life. Not just the gifted athlete.

—Bobbie Harris, Project Director for Physical Dimensions, the Kansas high school physical activity/wellness curriculum[35]

Being active for at least half of physical education class would provide a substantial portion of the overall physical activity time recommended for children and adolescents.

Physical education teachers should have the same teaching loads and class sizes as teachers of other subjects. Physical education teachers have a great deal of content to teach and, like other teachers, they cannot do their jobs effectively or have enough time to work with individual students if classes are overcrowded. As Dr. Joanne Owens-Nausler of the American School Health Association once said, "Try teaching English with 72 kids."

If students are to learn to enjoy physical activity, program planners must try to take into account their expressed interests. To the extent possible, students should look forward to physical education as a fun and important part of their day. Physical educators should also actively promote the participation of students' families in physical activity at home.

Assessment

Some school administrators, other staff, students, and parents might not consider physical education important unless student progress toward achieving course learning objectives figures into the assignment of course grades just as for any other subject.

Assessment of student performance in physical education is also essential for informing teachers about the effectiveness of specific instructional strategies used and to measure the overall success of the physical education program in attaining its instructional goals. Without program accountability, education decision makers are not likely to accept the importance of physical education, especially in the context of education reform.

Assessment needs to focus on the key content that should be addressed by physical education: knowledge about physical activity and movement, motor skills, and self-management skills. Assessment can be a combination of measuring students' achievement levels according to reasonable criteria, and appraising their degree of improvement over time.

As suggested earlier in the sample policy language, testing of health-related physical fitness (cardiorespiratory endurance, muscular strength and endurance, flexibility, and body composition) can have tremendous value as a diagnostic and instructional tool. However, it should not be used for grading individual students, assessing the performance of individual teachers, or measuring the effectiveness of a program because many factors that are beyond the control of schools and students— such as genetics, physical maturation, disabilities, and body composition— powerfully influence fitness test scores.

Considerable work has been done lately to develop state-of-the-art assessment practices for physical education. Materials to help schools design their assessment processes are available from NASPE.

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Brain-Compatible Learning

Today's brain, mind, and body research establishes significant links between movement and learning. Educators ought to be purposeful about integrating movement activities into everyday learning.... Brain-compatible learning means that educators should weave math, movement, geography, social skills, role play, science, and physical education together.

—Eric Jensen[5]

Exemptions from physical education

In a 1994 national survey, 23 percent of secondary schools reported that they exempt students from enrolling in physical education if they participate in school activities such as marching band, chorus, and cheerleading.[26] The sample policy in this document allows no substitutions based on participation in these kinds of school activities, even if the activities include physical exertion.

The reasoning for limiting exemptions is simple— instruction in physical education is an essential element of each student's learning and has education value beyond mere bodily movement; therefore, no one should be exempt from it. Consider an analogy: Should student members of debate clubs be granted exemptions from English language arts requirements? Should astronomy club members be exempted from science education?

Staff preparation

Studies have found that well-prepared physical education specialists teach longer and higher quality lessons.[3] Effective teaching of physical education requires a body of knowledge and instructional skills different from the skills that are necessary to teach other subject areas, including knowledge about motor development, exercise physiology, and motivating behavior change. It is essential for all teachers assigned to teach physical education to be ready and able to apply this body of knowledge and skills in ways appropriate to the age and developmental level of their students.

Yet for a number of reasons this imperative is not fully reflected in states' teacher certification requirements. Although 43 states require certification for teachers who teach physical education at the secondary school level, only eight states require that teachers who teach it at the elementary school level be certified.[26]

Even if certification is a state requirement, in reality many schools are not fully in compliance: a nationwide survey in 1994 found that one in four practicing physical education teachers in middle and high schools were not certified to teach the subject.[26]

If it is not possible to require that only teachers certified to teach physical education be assigned to teach it at the elementary school level, a less desirable alternative is to employ at least one certified physical education instructor per elementary school who is responsible for advising and mentoring others who teach physical education.

Physical education teachers need ongoing support and continuous professional development, but only 66 percent of lead secondary school physical education teachers reported receiving four or more hours of inservice training in 1992–94.[26] The most common topic of the training they received was "teaching sports or activities." In contrast, the topics listed most often by teachers as desired content for future training programs

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were how to develop individualized fitness programs for students, how to increase students' physical activity during physical education class, and how to involve families in physical activity.[26] These findings suggest that a great deal more professional development opportunities are needed if all schools' physical education programs are to be successfully reoriented to emphasize lifelong physical activity.

Physical activity topics in other curricular areas

Physical education should be closely coordinated with the overall school health program. In particular, physical education needs to be well coordinated with health education so that students thoroughly understand the benefits of being physically active and master the self-management skills needed to stay active for a lifetime. A good health education program will help students acquire important information, positive attitudes, and skills that reinforce lessons taught in physical education class.

Physical education topics can also be infused into other subjects such as math, science, and social studies. For example, the effects of television and computer games on people's daily physical activity habits might be a good social studies topic. Trajectories of students performing track-and-field activities could be analyzed in physics class.

Additional policy issues

Following are other policies that need to be in place for a successful physical education program that emphasizes lifelong physical activity:

- the overall learning climate of the school needs to consistently promote physical activity as positive and desirable;
- staff should never punish students for bad behavior by requiring physical activity, such as doing push-ups or running laps;
- general school policies that prohibit name calling or other forms of shaming, whether done by staff or by other students, must be consistently enforced in physical education settings; and
- sexual harassment, either between the genders or among students of the same gender, must never be condoned in physical education class— or at any other time at school.

Resources

- **The National Association for Sport and Physical Education** (NASPE) has developed the *National Standards for Physical Education: A Guide to Content and Assessment.* An extensive listing of other useful resources are also offered, including:
    - *Adapted Physical Education National Standards;*
    - *National Standards for Beginning Physical Education Teachers;*
    - *Physical Education Program Guideline and Appraisal Checklist for Elementary School;*
    - *Physical Education Program Improvement and Self-Study Guide: Middle School;*
    - *Physical Education Program Improvement and Self-Study Guide: High School;*
    - *Including Students with Disabilities in Regular Physical Education;*
    - *Substitution for Instructional Physical Education Programs;*
    - *Title IX Tool Box, Volumes I and II;*
    - *An Ethical Creed for Sport and Physical Educators;* and
    - *Liability and Safety in Physical Education and Sport: A Practitioner's Guide to the Legal Aspects of Teaching and Coaching in the Elementary and Secondary Schools.*

  To order resources call (800) 321-0789. For information call (703) 476-3410 or (800) 213-7193 x410, or go to www.aahperd.org/naspe.

  NASPE also sponsors NASPE-L, a listserv for K–12 physical educators.

- The **Putnam Valley School District** in New York State maintains Internet links to the standards documents of many states at http://putwest.boces.org/StSu/PE.html.

- Physical education curriculum materials for grades 3–5, developed for the Child and Adolescent Trial for Cardiovascular Health (CATCH), are available from the **National Heart, Lung, and Blood Institute** Information Center. Call (301) 251-1222 or go to www.nhlbi.nih.gov/nhlbi/cardio/other/prof/catchfly.htm.

- Asthma is a prevalent chronic health condition that affects many children's ability to participate in physical activity. The **National Asthma Education and Prevention Program** of the National Heart, Lung, and Blood Institute has produced a useful guide entitled *Asthma and Physical Activity in the School: Making a Difference*. Call (301) 251-1222.

- **Human Kinetics** offers a wide variety of materials that address all aspects of physical activity and sports. Call (800) 747-4457. Their Internet site at www.humankinetics.com includes an information center devoted to adaptive physical education.

- The **American Association for Active Lifestyles and Fitness** (AAALF) has published *The New Adapted Physical Education,* which can be used to plan activities for students included in regular physical education as well as in separate adapted physical education classes. Also available is *Guidelines for the Development of Fitness, Physical Activity, Recreation, and Sports Facilities* (1999). For information, call (800) 213-7193 or go to www.aahperd.org/aaalf. To order resources, call (800) 321-0789.

- **P.E. Central** bills itself as "the ultimate Web site for physical education teachers, students, and interested parents and adults." Go to http://pe.central.vt.edu.

- The **PELINKS4U** web site at www.cwu.edu/~jefferis/jeff_prorg.html is another Internet-based source for locating physical education teaching resources.

3. Extracurricular Physical Activity Programs

Schools should offer many opportunities for students to participate in enjoyable physical activity. Extracurricular physical activity programs can be vital supplements to students' educations as well as adding to their health and fitness.

Physical Activity Sample Policy, Part Three:

EXTRACURRICULAR PHYSICAL ACTIVITIES. Intramural programs, physical activity clubs, and interscholastic athletics are valuable supplements to a student's education. Schools shall endeavor to provide every student with opportunities to voluntarily participate in extracurricular physical activities that meet his or her needs, interests, and abilities. A diverse selection of competitive and noncompetitive, structured and unstructured activities shall be offered to the extent that staffing permits. The primary focus of extracurricular physical activity programs will be on facilitating participation by all interested students, regardless of their athletic ability. Equal opportunity on the basis of gender shall permeate all aspects of program design and implementation. School leaders shall endeavor to accommodate home-schooled children in extracurricular activities on a budget-neutral basis.

Each extracurricular physical activity program sponsored by in-school and non-school organizations shall be approved by *whom* and be supervised by a faculty advisor. The integrity and purpose of the physical education program shall not be compromised by such extracurricular activities, nor shall they interfere with the regular school schedule.

EXTRACURRICULAR PROGRAM ELIGIBILITY. School authorities should encourage and support the participation of all students in extracurricular activities, yet such participation is a privilege and not a right. *Schools/districts* may establish and equitably enforce reasonable eligibility requirements and probationary periods for participation in extracurricular activities. Such requirements may be based on:

- appropriate age;
- enrollment status or residency;
- satisfactory academic performance;
- acceptable attendance record;

- good conduct, including abstinence from the use of tobacco, alcohol, and other harmful drugs;
- agreement to testing for substance abuse;
- suitable health status or physical condition;
- other criteria essential to safety and fairness; or
- the specific requirements of particular activities or sports.

Eligibility requirements and appeal procedures shall be published in a regularly updated student activities handbook that is distributed to students and families annually. Students denied permission to participate in an extracurricular activity shall receive a prompt explanation of the reasons, have an opportunity to respond, and be provided with opportunities to reestablish their eligibility.

A student with a chronic health problem or other disabling condition shall be permitted to participate in any extracurricular activity, including interscholastic athletics, if the student's skills and physical condition meet the same qualifications that all other students must satisfy. The school shall make reasonable accommodations to allow the student to participate.

INTRAMURAL PROGRAMS. Elementary, middle, and high schools shall offer intramural physical activity programs that feature a broad range of competitive and cooperative activities and meet the following criteria:

- students have a choice of activities in which they can participate;
- every student has an opportunity to participate regardless of physical ability; and
- students have the opportunity to be involved in the planning, organization, and administration of the program.

INTERSCHOLASTIC ATHLETICS. High schools shall offer interscholastic athletic programs that shall adhere to the rules and regulations of *appropriate state or local leagues, associations, or conferences*. All coaches, whether volunteer or employed by *school/district*, shall comply with the policies, regulations, rules, and enforcement measures codified in a regularly updated coach's handbook.

Administrators, coaches, and other staff shall model sportsmanlike attitudes and behaviors. Student athletes shall be taught good sportsmanship, such as treating opponents with fairness, courtesy, and respect, and shall be held accountable for their actions. School authorities should evict spectators who do not handle themselves in a sportsmanlike way.

Partnerships between schools and businesses are encouraged, and business sponsorship of athletic teams shall be duly acknowledged. Nevertheless, advertising or other promotional activities supported by commercial interests are not permitted on public school grounds.

REQUIRED RECORDS. The parents or legal guardians of students who choose to participate in intramural programs, interscholastic athletics, or school-linked community recreation programs shall be informed in writing of potential risks associated with a given activity. Schools must keep documentation on file for each participating student that includes:

1. a statement signed by the student's parent/guardian granting permission for the student's participation;
2. emergency contact information for the student's parents/guardians and health care providers;
3. a thorough health appraisal (physical examination) certifying the student's fitness to participate that is appropriate to the activity or sport, conducted within the past 12 months, and signed by a licensed physician;
4. proof of current accident or health insurance coverage; and
5. a release signed by a parent/guardian that absolves the school or district from liability for injuries that may result from participation in school-sponsored physical activities unless negligence on the part of staff or coaches is proven.

FEES. Schools may establish reasonable fees for extracurricular activities and/or interscholastic athletic programs. Students from families who are documented to be financially disadvantaged shall be promptly granted waivers on a confidential basis upon written parental request.

STAFFING. All intramural programs, physical activity clubs, and athletic teams shall be supervised by qualified staff, who may or may not be certified teachers.

Intramural and athletic program staff shall satisfactorily complete courses or other professional development programs that address:

- child and adolescent physical development;
- sports-related injury prevention and safety guidelines;
- infection control procedures;
- first aid and cardiopulmonary resuscitation techniques;
- promotion of healthy student behaviors;

- safe and unsafe methods for youth weight management and conditioning; and
- how to provide students with experiences that emphasize enjoyment, sportsmanship, skill development, confidence building, and self-knowledge.

Intramural and athletic program staff shall also have satisfactorily completed a supervised probationary period and must regularly participate in relevant staff development programs.

VOLUNTEER ATHLETIC AIDES. Family members and other adult volunteers are encouraged to become involved with extramural or athletic activities. All volunteers shall receive orientation about relevant state, district, and school policies, procedures, and standards of conduct and may be subject to background and reference checks. Volunteer athletic aides shall satisfactorily complete training that addresses, at a minimum:

- basic child and adolescent physical development;
- sports-related injury prevention and safety; and
- first aid and cardiopulmonary resuscitation.

Discussion

Extracurricular activities can enrich the school experience for students, teach valuable lifelong lessons, and add to students' physical and emotional development. Studies have found that students who participate in extracurricular programs such as sports, music, and debate tend to have higher grade point averages, better attendance records, lower dropout rates, and fewer discipline problems than students generally[37] (see box, "A Case for Extracurricular Activities," on the next page). With sound planning, extracurricular activities can be a worthy extension of a good education program.

A Vital Part of the Educational Program

The Board believes that student activities at school are a vital part of the total educational program and should be used as a means for developing wholesome attitudes and good human relations, as well as knowledge and skills. The Board believes that school citizenship, as reflected in student activities, is a measure of the achievement of important school goals. The Board recognizes that the greatest values to be derived from both curricular and extracurricular student school activities occur when such activities are developed and encouraged through participation among, or the knowledge of, the student body, interested members in the community, and school staff.

—Horseheads Central School District, New York[36]

Intramural Programs

Interscholastic sports programs have been much more firmly established as part of the American educational system than intramural programs. In 1994, 82 percent of middle/junior high schools and 94 percent of senior high schools offered interscholastic sports programs, but only 51 percent of the former and 38 percent of the latter offered intramural sports programs.[21] However, it is through intramural programs, rather than interscholastic sports programs, that substantial improvements are likely to be made in the rates of youth participation in physical activity.

Participation in interscholastic sports is often limited to those students who have demonstrated athletic proficiency. In contrast, the focus of intramural programs is on

A Case for Extracurricular Activities

At a cost of only one to three percent (or less in many cases) of a school's overall budget, high school activity programs are one of the best bargains around.... Following are some of [the documented] benefits:

The Role of Sports in Youth Development **from the Carnegie Corporation of New York, a report of a meeting in March 1996, found that...at their best, sports programs promote responsible social behaviors and greater academic success, confidence in one's physical abilities, an appreciation of personal health and fitness, and strong social bonds with individuals and institutions. Teachers attribute these results to the discipline and work ethic that sports require.**

Adolescent Time Use, Risky Behavior, and Outcomes: An Analysis of National Data, **issued in September 1995 by the U.S. Department of Health and Human Services, found that students who spend no time in extracurricular activities are 57 percent more likely to have dropped out of school by the time they would have been seniors; 49 percent more likely to have used drugs; 37 percent more likely to have become teen parents; 35 percent more likely to have smoked cigarettes; and 27 percent more likely to have been arrested than those who spend one to four hours per week in extracurricular activities.**

School-age children and teens who are unsupervised during the hours after school are far more likely to use alcohol, drugs, and tobacco; engage in criminal and other high-risk behaviors; receive poor grades; and drop out of school than those children who have the opportunity to benefit from constructive activities supervised by responsible adults. In a 1994 Harris poll, more than one-half of teachers singled out "children who are left on their own after school" as the primary explanation for students' difficulties in class. This information comes from the National Education Commission on Time and Learning.

A 1989 nationwide study by the Women's Sport Foundation indicated that athletes do better in the classroom, are more involved in school activity programs, and stay involved in the community after graduation. The study also revealed that high school athletic participation has a positive educational and social effect on many minority and female students. The study, based on an analysis of data collected by the U.S. Department of Education's High School and Beyond Study, indicated that: 1) Girls receive as many benefits from sports as boys. 2) The "dumb jock" stereotype is a myth. 3) Sports involvement was significantly related to a lower dropout rate in some school settings. 4) Minority athletes are more socially involved than minority non-athletes.

Findings from the National Center for Education Statistics, ***Extracurricular Participation and Student Engagement,*** **June 1995, revealed that during the first semester of their senior year, participants reported better attendance than their non-participating classmates. Half of them had no unexcused absences from school and half had never skipped a class, compared with one-third and two-fifths of non-participants, respectively. Students who participated were three times as likely to perform in the top quartile on a composite math and reading assessment compared with non-participants. Participants also were more likely than non-participants to aspire to higher education; two-thirds of participants expected to complete at least a bachelor's degree, while about half of non-participants expected to do so.**

—National Federation of State High School Associations[17]

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creating opportunities to increase *all* students' participation in physical activity. Whereas interscholastic sports emphasize competition and winning, intramurals emphasize participation and enjoyment without pressure. Intramural programs, therefore, are particularly beneficial for those who could benefit most from increased participation in physical activity: the large number of students who lack the skills or confidence to play interscholastic sports, as well as those who dislike competitive sports altogether.

The types of activities available to students in intramural programs can vary tremendously and can include:[38]

- leagues and tournaments for sports such as flag football, basketball, softball, and tennis;
- clubs for fitness and recreational activities such as weightlifting, hiking, dancing, and aerobic workouts; and
- self-directed activities such as walking, jogging, and stretching.

Intramural programs provide more flexibility than interscholastic programs in meeting the physical activity needs of female students. Girls are less likely than boys to participate regularly in vigorous physical activity and to participate in interscholastic sports programs.[10,39] In 1997, 56 percent of male high school students reported that they played on sports teams run by their school, compared with only 42 percent of female high school students.[10] School intramural programs can offer a variety of noncompetitive physical activity options and can be custom designed at the school level to meet specific interests of girls.

Lack of funding is probably the largest barrier to implementation of intramural physical activity programs, but some schools have developed creative approaches for overcoming this barrier. For example, the West Des Moines School District collaborated with the Walnut Creek YMCA and their local parks and recreation department to create an intramural program for middle and high school students who do not participate on interscholastic teams. Activities include flag football, wrestling, volleyball, dance, fishing, and a year-round fitness club. The school board pays for staff salaries, program equipment, facilities, and transportation; the YMCA and the park district help school-based intramural directors with program development, provide trained adults to serve as coaches, and manage program finances for each of the participating schools.[40]

Eligibility requirements

Eligibility requirements for student participation in extracurricular activities can vary widely from one school to another. Many schools and districts follow the guidance of the National Federation of State High School Associations (NFHS) or its state affiliates. Some also cite the rules of the National Collegiate Athletic Association (NCAA) regarding eligibility standards for college-bound student athletes (see the list of resources at the end of this section). Sixteen states have established minimum academic requirements for students' participation in athletics, often referred to as "no-pass, no-play" rules.[41]

Each community must find its own balance between competing perspectives about eligibility requirements. On the one hand, schools' primary mission is education. Strict

One State's Experience with "No-Pass, No Play"

In 1993 Arkansas instituted a minimum 2.0 grade point average (GPA) requirement for students to participate in extracurricular activities. The result was a dramatic increase in the number of students not allowed to participate: 22 percent of the state's entire high school enrollment in the 1995–96 school year. Minority students were especially affected.

In response, the Arkansas State Board of Education amended its policy in January 1998 to de-emphasize the strictly punitive nature of the rule. The board established a set of eligibility rules that are more flexible and provide incentives for poorly performing students to seek remedial and additional instruction in order to maintain their eligibility.

—National Association of State Boards of Education[41]

academic requirements for eligibility appear to effectively motivate some students to study harder. On the other hand, sports and other extracurricular activities play a valuable role in the lives of some students who might drop out of school if they are not permitted to participate.

This dilemma can be softened by ensuring that students' academic shortcomings are identified and addressed at an early stage; that remedial help is available to students deemed ineligible; and that ineligible students are shown a feasible path for quickly restoring their privileges if they study hard.

Many families of home-schooled students request the opportunity for their children to partake in extracurricular activities offered at public schools. At least six states now have laws to specifically allow this.[41]

Agreement to possible testing for substance abuse is a reasonable condition for a student's eligibility to participate in extracurricular activities, as long as all students are requested to satisfy the condition and not just some individuals who are targeted for special attention. The NFHS provides useful information on how to legally establish a drug-testing program at www.nfhs.org/drug_testing.html.

Federal laws prohibiting discrimination

According to federal law— specifically, Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (ADA)— schools must allow a student with any kind of disabling condition to participate in extracurricular activities, including joining

Sportsmanship Defined

Sportsmanship involves:

- **Taking a loss or defeat without complaint.**
- **Taking victory without gloating.**
- **Treating opponents with fairness, courtesy, and respect.**

The following behavior [by an athlete or spectator] is unacceptable at all school contests:

- **Berating an opponent's school or mascot.**
- **Berating opposing players.**
- **Obscene cheers or gestures.**
- **Negative signs.**
- **Words or gestures of complaint about officials' calls.**

At the start of all athletic competitions, the announcer shall explain and promote sportsmanship expectations.

—California School Boards Association[42]

an athletic team, if the student is "otherwise qualified" (that is, if the student's skills and physical condition satisfy the same qualifications that everyone else must satisfy). Schools also have to make "reasonable accommodations" to allow the student to participate (phrases in quotation marks have precise legal definitions).[43]

Another federal law, Title IX of the Education Amendments of 1972, has had far-reaching effects on young women's participation in school athletic programs. The law states that, "No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance...." In 1996, 2.4 million high school girls represented 39 percent of all high school athletes, compared with only 300,000 or 7.5 percent in 1971.[44]

Title IX applies to nearly all public and most private schools. The regulations enforced by the Office for Civil Rights (OCR) of the U.S. Department of Education list 10 factors that should be considered in determining whether equal opportunities are available:[45]

1. whether the selection of sports and levels of competition effectively accommodate the interests and abilities of members of both sexes;

2. provision of equipment and supplies;

3. scheduling of games and practice;

4. travel and per diem allowance;

5. opportunity to receive coaching and academic tutoring;

6. assignment and compensation of coaches and tutors;

On Separating Students by Sex

With certain exceptions, elementary and secondary schools may not assign students to separate classrooms or activities, or prevent them from enrolling in a course of their choice, on the basis of sex.... Exceptions [pertaining to physical activity] are:

- **Students may be separated by sex when participating in sports where the major purpose or activity involves bodily contact (for example, wrestling, boxing, rugby, ice hockey, football, and basketball).**

- **Students may be grouped in physical education classes by ability, if objective standards of individual performance are applied. This may result in all-male or all-female ability groups.**

- **If the use of a single standard to measure skill or progress in a physical education class has an adverse effect on members of one sex, schools must use appropriate standards that do not have such an effect. For example, if the ability to lift a certain weight is used as a standard for assignment to a swimming class, application of this standard may exclude some girls. The school would have to use other appropriate standards to make the selection for that class.**

A school system that operates separate educational programs or activities for members of each sex in accordance with the mentioned exceptions must ensure that the separate courses, services, and facilities are comparable.

An exemption from these requirements may be requested by educational institutions controlled by religious organizations whose tenets conflict with requirements of Title IX.

—Office for Civil Rights, U.S. Department of Education[46]

7. provision of locker rooms, practice, and competitive facilities;

8. provision of medical and training facilities and services;

9. provision of housing and dining facilities and services; and

10. publicity.

In practice, courts tend to analyze the first factor concerning equal accommodations separately; the remaining nine are generally considered together in determining whether there is equivalence.[45] The first factor tends to be the most litigated. It is also widely misunderstood. The regulation does not require a school to fully integrate all its athletic teams, nor does it require that exactly the same choice of sports be available for young men and women. Rather, courts tend to focus on overall athletic opportunities and spending as they relate to enrollments and students' interests and abilities.

Coaching qualifications

Qualifications of coaches are determined state by state and district by district. Traditionally, the major requirement has been that coaches have teaching certificates, but the recent trend has been to mandate that individuals complete coaching education programs. As of 1996, 27 states required coaching education.[47]

As most injuries occur during practice when physicians and trainers are less likely to be present, it is imperative that coaches know how to prevent and treat injuries. Guidance on establishing qualifications can be obtained from NASPE, which has published national standards for athletic coaches, and NFHS, which offers an interscholastic coaches education program (see the resources list).

Many schools and districts maintain a regularly updated coach's handbook of policies and procedures regarding intramural and interscholastic athletic programs for reference by school athletic staff and volunteer athletic aides. Some legal experts recommend that, before a school or district uses volunteers in athletic programs, position descriptions be developed that detail the functions expected to be performed by the volunteer, the required qualifications, the scope of the volunteer's authority, and any benefits or expense reimbursements provided.[47]

Resources

- Your state education department or state school boards association might be able to provide detailed guidance and assistance about eligibility requirements for athletic and other extracurricular activities.

- The **National Association for Sport and Physical Education** (NASPE) offers an extensive number of useful resources, including:

  - *National Standards for Athletic Coaches;*
  - *Checklist for Safety in Sports;*
  - *Certified Athletic Trainers in the High School;* and
  - *Exploitation of the Interscholastic Athlete.*

  For information call (703) 476-3410 or (800) 213-7193 x410 or go to www.aahperd.org/naspe. To order resources call (800) 321-0789.

- The **National Intramural Sports Council**, a joint structure of NASPE and the National Association for Girls and Women in Sport (NAGWS), addresses policies and issues related to intramural sports programs and offers a brochure, *Guidelines for School Intramural Programs*, that outlines indicators of a good program. NAGWS also published *Title IX Tool Box, Volumes I and II.* Call NAGWS at (800) 213-7193 or (703) 476-3400.

- **The National Intramural and Recreational Sports Association** (NIRSA) is a nonprofit professional association whose mission is to foster quality recreational programs, facilities, and services for diverse populations. NIRSA is developing a manual for implementing intramural programs for students in grades K–12. Go to www.nirsa.org.

- **The National Federation of State High School Associations** (NFHS) has a large number of resources concerning interscholastic sports issues. Contact (816) 464-5400 or www.nfhs.org.

- *The NCAA Guide for the College Bound Student-Athlete* is a summary of the rules and regulations of the **National Collegiate Athletic Association** (NCAA) related to recruiting, eligibility, financial aid, and college freshman eligibility requirements. The entire guide is available on the Internet at www.ncaa.org/eligibility/cbsa. Eligibility information is also available at (800) 638-3731.

- The School Health Resource Database of the **National Schools Boards Association** (NSBA) contains a large number of school district policies and support documents on topics such as eligibility rules for interscholastic athletics. Call (703) 838-6722 or send an e-mail request to schoolhealth@nsba.org.

- The *Legal Handbook on School Athletics* from the **National School Boards Association** (NSBA) addresses a broad range of legal issues including discipline of school athletes, eligibility rules, participation of non-public school children, testing for substance abuse, Title IX, prayer at athletic events, liability for spectators, and athletic personnel and volunteers. Call (703) 838-6722.

- See the article from the **ERIC Clearinghouse on Teaching and Teacher Education** entitled "Promoting Gender Equity in Middle and Secondary School Sports Programs" online at www.ed.gov/databases/ERIC_Digests/ed367660.html.

- The **Office for Civil Rights** of the U.S. Department of Education offers an eight-page pamphlet on *Student Assignment in Elementary and Secondary Schools & Title IX* (1988, Code No. 17) to assist educators in their efforts to comply voluntarily with federal regulations. Single copies are available by mail from the U.S. Department of Education Office for Civil Rights, Customer Service Team, 330 C Street, SW, Washington, DC 20202. Additional guidance is available at www.ed.gov/OCR.

- Guidance on religious expression in the public schools and school athletic programs is available from the **U.S. Department of Education**. Call (800) USA-LEARN or go to www.ed.gov/Speeches/08-1995/religion.html.

4. Other Opportunities for Physical Activity

All schools need to offer convenient opportunities for students and staff to participate in enjoyable physical activity, and this imperative should be enshrined in policy. Recess in elementary schools is particularly important. In addition, policymakers can help build partnerships between schools and their communities by addressing issues that concern community use of school physical activity facilities.

Physical Activity Sample Policy, Part Four:

RECESS IN ELEMENTARY SCHOOLS. Recess provides opportunities for physical activity, which helps students stay alert and attentive in class and provides other educational and social benefits. School authorities shall encourage and develop schedules that provide time within every school day for preschool, kindergarten, and elementary school students to enjoy supervised recess. Every school shall have playgrounds, other facilities, and equipment available for free play. Recess shall complement, not substitute for, physical education classes. Staff shall not deny a student's participation in recess or other physical activity as a form of discipline or punishment, nor should they cancel it for instructional makeup time.

SCHOOL/COMMUNITY COLLABORATION. Schools shall work with recreation agencies and other community organizations to coordinate and enhance opportunities available to students and staff for physical activity during their out-of-school time.

Schools are encouraged to negotiate mutually acceptable, fiscally responsible arrangements with community agencies and organizations to keep school- or district-owned facilities open for use by students, staff, and community members during non-school hours and vacations. School policies concerning safety shall apply at all times.

STAFF PHYSICAL ACTIVITY. The school/district shall plan, establish, and implement activities to promote physical activity among staff and provide opportunities for staff to conveniently engage in regular physical activity.

Discussion

Regularly scheduled periods within the school day for unstructured physical activity and play, commonly referred to as "recess" periods, have long been a staple of the elementary school schedule. A 1986 national study found that students in grades one through four spent, on average, 30.1 minutes per day in recess.[48] However, in recent years, an increasing number of elementary schools have cut back on time allocated for recess.[49] In fact, some large school districts have eliminated recess altogether because of concerns about student safety and/or a desire to increase the amount of time devoted to academic instruction.[50] Yet, encouragingly, parent protests have put a halt to administrators' plans to eliminate recess in some school districts.[50]

In 1998 the National Association for Sport and Physical Education (NASPE) issued physical activity guidelines for children ages 6–11, which recommend that children accumulate *at least* one hour and *up to* several hours of physical activity each day.[16] This could occur appropriately in multiple periods of moderate to vigorous activity lasting 10 minutes or more. NASPE argues that recess is "a critical part of the school day" and that "extended periods of inactivity are not appropriate for normal, healthy children or adults."[51]

The National Association of Elementary School Principals (NAESP) continues to support recess: at its 1999 convention, NAESP endorsed recess as "an important component in a child's physical and social development" and encouraged principals to "develop and maintain appropriately supervised, unstructured free play for children during the school day."[52] A 1991 survey conducted by NAESP found that most of the 383 principals surveyed believed recess has educational and social value and is worthwhile.[53]

Recess promotes physical activity, in part, by simply getting children outdoors; studies have shown that the time young children spend outdoors is positively associated with their levels of physical activity.[55,56] Schools might

The Case for Recess

Recess contributes to the child's cognitive and intellectual needs...

- **Students who do not get a break are much more fidgety in the classroom and are deprived from interacting with different peers and watching and learning from other children.**
- **Unstructured play gives the child an opportunity to exercise a sense of wonder, which leads to exploration, which leads to creativity.**

Recess responds to the child's social and emotional needs...

- **Recess can serve as an outlet for reducing or lowering the child's anxiety... a means for the child to manage stress.**
- **If we eliminate recess, we are ignoring the fact that for many children the opportunity to play with friends is an important reason for coming to school.**
- **A vital aspect of play is the non-threatening way children of different cultures learn from each other.**
- **Some children need the opportunity to break away from their classmates to collect their thoughts in solitary play.**
- **Recess provides opportunities for children to explore many types of active play regardless of the stereotypical expectations associated with gender.**
- **Traditional recess activities like jump rope, kickball, and hopscotch encourage children to take turns, negotiate or modify rules, and interact cooperatively.**

—American Association for the Child's Right to Play[54] be able to facilitate increased physical activity during recess periods by having staff encourage students to be active and by providing students with space, facilities, equipment, and supplies that can make participation in physical activity appealing to them. To have enough time for classroom lessons, physical education courses, and recess, NASPE suggests that school systems consider extending the length of the school day.[51]

Attentiveness

Every study shows that children are more attentive after recess—as the kids would say, "Well, duh!"

—Tony Pellegrini[41]

In addition to its contribution to physical activity time, recess has also been valued for its social and cognitive benefits. Recess offers students one of their few opportunities during the school day to interact and develop social skills, such as negotiating and cooperating, with minimal adult interference. Studies have found that students who do not participate in recess become fidgety and less able to concentrate on tasks and that the longer children sit in classrooms without a recess break, the less attentive they become.[57,58,59]

Researchers have found that students are more likely to learn social skills when recess play is left unstructured— that is, when children are allowed to decide for themselves how to spend their recess time.[57] Unstructured should not be confused with unsupervised: schools need to have an appropriate number of adults on hand to enforce safety rules and prevent aggressive, bullying behavior.

School equipment and supplies used during recess must be developmentally appropriate and meet established safety standards (see the following section on "Safety Guidelines"). In addition, schools need to work with police departments and community agencies to address concerns that educators and parents might have about taking children to play outdoors in high-crime neighborhoods.

Schools that schedule recess time around the school lunch period are advised to have recess before lunch, as opposed to after lunch. Studies have found that students eat more and waste less of their lunch food when they have recess before lunch.[60,61] Perhaps this is because they develop a greater appetite after the expenditure of time and energy in recess, or because many of those who eat lunch before recess rush through their meals in order to get outside to play.

School/community collaboration

Community organizations— such as parks and recreation departments, YWCAs and YMCAs, Boys and Girls Clubs, golf courses, tennis courts, swimming pools, and private health clubs— are all candidates for collaboration to supplement the school physical activity program. Schools often have good facilities that remain closed in the evenings, on weekends, and during school breaks, and community-based programs often have organized activities that suffer from a lack of space and equipment.

Schools' legitimate concerns about liability, maintenance costs, and supervision are not insurmountable obstacles. Negotiations conducted in a cooperative spirit and focused on mutual goals can usually result in "win-win" solutions. These solutions might involve collaborative funding and staffing arrangements.

For instance, West Virginia's Clay County, which formed a school/community coalition named "Clay Organized for Wellness" (COW) with technical assistance from NASBE, demonstrated that a good first step is to jointly conduct a community needs assessment.[62] With a common action plan, special funding was then jointly sought from foundations and government agencies.

Schools also might find that providing the community with greater access to school physical activity facilities could lead to enhanced community support for the public financing of school facilities.[63] In addition, schools might be able to obtain access to community facilities for school physical activity programs.

Physical activity opportunities for staff

Providing staff with health promotion services, including opportunities to participate in physical activity, is a key component of a coordinated school health program for several reasons:

- evaluations have found that participation in school health promotion programs for staff can increase morale, increase participation in vigorous activity, improve physical fitness, facilitate weight loss, lower blood pressure, and improve stress management skills;[64,65]
- teachers who become interested in their own health tend to take a greater interest in the health of their students and become more effective teachers of health;[66] and
- teachers can influence student behaviors by being powerful role models for a physically active lifestyle.

Resources

- Your state or local departments of education, public health, or recreation or your state's school boards association might be able to provide assistance with program planning or offer other resources.
- The **American Association for the Child's Right to Play** provides a fact sheet and other information on the benefits of recess. Go to www.ipausa.org.
- *Active Youth: Ideas for Implementing CDC's Physical Activity Promotion Guidelines* (1998) describes several successful physical activity programs that have built bridges between schools and communities. It is available from **Human Kinetics** at (800) 747-4457 or go to www.humankinetics.com.

5. Safety Guidelines

Policymakers need to send a clear message that safety and health are priority policy areas. Of particular importance is establishing and enforcing health and safety rules for students and staff, safety standards for facilities and equipment, and policies on substance abuse that address performance-enhancing drugs.

Physical Activity Sample Policy, Part Five:

RESPONSIBILITY FOR SAFETY. Minimizing injuries and illnesses related to physical activity is the joint responsibility of everyone: district and school leaders, school staff, students, and their families.

HEALTH AND SAFETY RULES. Schools shall establish rules and procedures concerning safety, infection control, provision of first aid, and the reporting of injuries and illnesses to students' families and appropriate school and community authorities. School administrators shall strictly and consistently enforce compliance with these rules and procedures by all students, school personnel, volunteers, and community members who use school facilities. Students and their families shall be informed of their school's health and safety rules at least annually.

Schools shall require students to use protective clothing and equipment appropriate to the activity and the environment, which will be maintained in good condition. Physical education teachers, coaches, and other athletic personnel and volunteers shall protect students from the effects of extreme weather conditions and endeavor to minimize the amount of exposure to the sun students receive during physical activities.

SAFE FACILITIES. Play areas, facilities, and equipment used for physical activity on school grounds shall meet accepted safety standards for design, installation, and maintenance. Spaces and facilities shall be kept free from violence and exposure to environmental hazards. All spaces, facilities, and equipment used by students and spectators to athletic events shall be thoroughly inspected for health and safety hazards on a regularly scheduled basis, at least twice per year. Written inspection reports shall be kept on file for 10 years. Schools shall correct any hazards before the facilities or equipment may be used by students, staff, or community members.

SUPERVISION. Student physical activity on school grounds during school hours shall be supervised to enforce safety rules and prevent injuries. Supervision shall be by adults trained in first aid, cardiopulmonary resuscitation, and infection control who have easy access to appropriate first aid supplies. Records shall be kept of all injuries and analyzed at least annually so that patterns of causes can be determined and steps can be taken to prevent further injuries.

Supervising adults shall be informed of any relevant medical guidance on file with the school concerning limits on the participation of individual students in physical activity. Such information will be treated with strict confidentiality.

SUBSTANCE USE. School staff and other athletic personnel shall never condone, and must actively discourage, any student use of drugs, steroids, or hormones to enhance appearance or athletic performance. Coaches and athletic trainers shall encourage young people to maintain a healthy diet; practice healthy weight management techniques; and abstain from using tobacco, alcohol, and other drugs.

Existing policies that prohibit drug possession and use shall fully apply to the use or possession of steroids, hormone treatments, and other performance-enhancing drugs. Established policies on student medications shall apply to student consumption or possession of dietary supplements while on school grounds.

Discussion

Public school districts have a legal duty to exercise reasonable care in operating physical activity programs, or they may incur liability for injuries. Grounds for liability suits that have been successfully advanced against schools include:

- failure to provide adequate supervision;
- failure to instruct or warn;
- failure to provide proper safety equipment;
- negligently allowing unfit students to participate in athletic activities;
- failure to exercise reasonable care in matching participants in athletic activities;
- failure to exercise reasonable care in selection of athletic personnel;
- failure to properly maintain premises;
- failure to provide safe transportation; and
- failure to provide adequate post-injury health care.[68]

Policy on Athletic Injuries

No student should be allowed to practice or play in an athletic contest if he/she is suffering from an injury. The diagnosis of and prescription of treatment for injuries is strictly a medical problem and should, under no circumstances, be considered a province of the coach. A coach's responsibility is to see that an injured player is given prompt and competent medical attention and that all details of a doctor's instructions concerning a student's functioning as a team member are carried out. No student will be allowed to practice or compete if there is a question that he/she is not in adequate physical condition.

—Bannock School District, Idaho[67]

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Liability for Spectators

The standard of care imposed on schools by the courts generally is that schools have a duty to protect spectators from all *foreseeable and unreasonable risks* of harm. While at first glance this duty may seem very broad, it is important to note that the courts have held that schools are not the insurers of spectators. The duty is not to protect against *all possible* harm, no matter how remote, but only to protect against all reasonable harm based on common sense and past experience with the particular game.

—National School Boards Association[69]

In addition to the possibility of students' injuries sustained during physical education or other physical activity programs, schools also must be sensitive to possible injuries to spectators who are watching extracurricular athletic activities.

One way schools can guard against liability suits is to collect data on all injuries, analyze the data regularly, and correct hazards associated with injuries as they are identified.

Facilities and equipment

According to CDC's National Center for Injury Prevention and Control, each year more than 200,000 children go to hospital emergency rooms with injuries associated with playground equipment— about one injury every 2½ minutes.[71] Most injuries occur when children fall off swings, monkey bars, climbers, or slides. Each year, anywhere from 9 to 17 children die from playground injuries.[71] Experts say that many deaths and injuries could be prevented if playgrounds— from equipment to surfacing to layout— were designed with safety in mind (see box, "Public Playground Safety Checklist").

Safety Hotline

If you want to report an unsafe consumer product or have a product-related inquiry, call the toll-free hotline of the U.S. Consumer Product Safety Commission at (800) 638-2772, or (800) 638-8270 for the hearing and speech impaired.

Public Playground Safety Checklist

- **Make sure *surfaces* around playground equipment have at least 12 inches of wood chips, mulch, sand or pea gravel or are mats made of safety-tested rubber or rubber-like materials.**
- **Check that protective *surfacing extends* at least six feet in all directions from play equipment. For swings, be sure surfacing extends, in back and in front, twice the height of the suspending bar.**
- **Make sure play structures more than 30 inches high are *spaced* at least nine feet apart.**
- **Check for *dangerous hardware*, like open "S" hooks or protruding bolt ends.**
- **Make sure *spaces* that could trap children, such as openings in guardrails or between ladder rungs, measure less than 3.5 inches or more than 9 inches.**
- **Check for *sharp points or edges* in equipment.**
- **Look out for *tripping hazards*, like exposed concrete footings, tree stumps, and rocks.**
- **Make sure elevated surfaces, like platforms and ramps, have *guardrails* to prevent falls.**
- ***Check playgrounds regularly* to see that equipment and surfacing are in good condition.**
- ***Carefully supervise* children on playgrounds to make sure they're safe.**

—U.S. Consumer Product Safety Commission[70]

Whereas more elementary school-aged children are injured on playgrounds than anywhere else at school, middle and high school students sustain most injuries while involved in sports.[72] Actions to be taken to prevent sports injuries include maintaining athletic fields for smooth, flat surfaces; securing and padding football goalposts; making sure that baseball bases break away; and padding gymnasium walls.

The resource list at the end of this section includes many organizations that have developed safety standards and inspection protocols for a wide range of physical activity facilities and equipment.

Sun exposure

A commonly overlooked safety issue is prevention of skin cancer. Skin cancer is among the most common types of cancer and the incidence of melanoma, the deadliest form of skin cancer, has been rising in the United States.[73] Medical professionals are concerned that young people who are overexposed to sunlight are more likely to develop skin cancer later in life. Scientists have found that even a few serious burns can increase the risk of skin cancer.[74]

The amount of harmful sun exposure depends on the strength of the light, the length of exposure, and whether a person's skin is protected. To the extent feasible, school leaders should:

- schedule physical activity programs to minimize students' sun exposure, especially during the midday;
- plant shade trees, construct shaded walkways, and use grass as a ground cover rather than sand or concrete that reflects sunlight;
- insist that students wear protective clothing, broad-rimmed hats, and sunglasses on sunny days; and
- encourage students, particularly fair-skinned students, to apply sunscreen to all exposed areas of the body. The sunscreen should have a sun protective factor (SPF) of 15 or higher with UVA and UVB protection.

Although rates of skin cancer are highest among individuals with fair skin, some individuals with dark skin also burn easily. It is important for *all* children and adolescents to protect themselves from the sun.

Infection control

Although the risk that cuts and abrasions might transmit a blood-borne virus such as hepatitis or HIV is extremely low[43] (see the appendix at the end of this section, "HIV, AIDS, and School Athletics"), prudence dictates that schools establish infection control guidelines and rigorously enforce them.

All students, school staff, and athletic staff must learn and routinely apply infection control procedures for handling blood and other body fluids that might contain blood. The similar but more exacting guidelines used in clinical health care settings are called "universal precautions" because they are based on the principle that the procedures must apply *to all persons* and *at all times*, whether or not a disease threat is known to exist. A student or staff member might be carrying a harmful pathogen and not realize it. A chart of infection control guidelines adapted specifically for schools appears on the following page.

Infection Control Guidelines for Schools

Follow these guidelines at all times and with all individuals to prevent infection with HIV, hepatitis B virus, and other disease-causing agents:

Caring for Wounds

Do not be afraid to help a bleeding person.

- ☆ *A person with a bleeding wound or bloody nose should apply pressure on it. If necessary, another person can help by pressing the bleeding person's hand.*
- ☆ *Keep skin cuts, abrasions, and sores clean and covered.*
- ☆ *Use a barrier to avoid direct contact with blood (or any body fluid that might contain blood). Use latex gloves if possible, or whatever is handy, such as clothing or a thick wad of paper.*

Cleaning Up

Hand washing helps prevent transmission of many kinds of disease-causing organisms.

- ☆ *Remove each glove without exposing skin to the glove's exterior.*
- ☆ *Always wash hands promptly and thoroughly with soap and warm water after contact with blood or body fluids that might contain blood, even if gloves or other barriers were used.*
- ☆ *Wash hands with powder or liquid soap, and dry with disposable towels.*
- ☆ *Use tissues, paper towels, or moist towelettes to clean up small amounts of blood.*
- ☆ *Clean surfaces where blood or other body fluids were spilled with a germicidal cleaning agent. Common bleach diluted at one part bleach to 100 parts water (three tablespoons per gallon) can be used: a bleach mixture loses its strength within a day.*
- ☆ *Cover spill of blood, vomit, and urine with absorbent sweep material to prevent fluids from spreading, then clean it up using standard procedures.*

Disposal

- ☆ *Do not reuse thin latex gloves. Rubber utility gloves can be cleaned, but discard any that are torn, punctured, cracked, or otherwise deteriorated.*
- ☆ *Discard in a sturdy plastic bag all bandages, disposable gloves, and materials used in cleaning spilled blood. Tie the bag and place it into a leakproof container where it will not be disturbed until picked up for disposal.*
- ☆ *Rinse and then seal a child's blood-stained clothes in a plastic bag to send home for laundering.*

Supplies

- ☆ *First aid kits should include:*
  - ☐ *Disposable latex gloves in several sizes*
  - ☐ *Absorbent bandages and gauze pads in a variety of sizes*
  - ☐ *Antiseptic pre-moistened towelettes*
  - ☐ *Leakproof plastic bags with ties*
- ☆ *Place secure sanitary napkin disposal containers in rest rooms.*
- ☆ *Stock science laboratories, sewing rooms, and shops with secure disposal containers for items that come into contact with blood.*
- ☆ *Playground monitors and athletic trainers should carry pouch containing latex gloves, bandages, and towelettes.*

Prevention

- ☆ *Teach students to take care of their own minor scrapes and cuts, and to wash their hands before and after these procedures.*
- ☆ *Personal items such as toothbrushes, towels, or razors should not be shared at school.*
- ☆ *Keep school grounds clean of broken glass and other sharp objects.*

School health services personnel should use the detailed guidelines on universal precautions for health care settings, available from the CDC National Prevention Information Network at (800) 458-5231 or www.cdcnpin.org.

—National Association of State Boards of Education[43]

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Performance-Enhancing Supplements

Use of any drug, medication, or food supplement in a way not prescribed by the manufacturer should not be authorized or encouraged by school personnel and coaches. Even natural substances in unnatural amounts may have short-term or long-term negative health effects.

In order to minimize health and safety risks to student-athletes, maintain ethical standards, and reduce liability risks, school personnel and coaches should never supply, recommend, or permit the use of any drug, medication, or food supplement solely for performance-enhancing purposes.

—NFHS Sports Medicine Advisory Committee[75]

All school staff, particularly physical education teachers and athletic program staff, should be required to complete a first aid and injury prevention course that includes implementation of infection control guidelines. Students' health education classes and sports orientations need to cover the guidelines as well.

In addition, equipment and supplies required to apply the infection control guidelines need to be maintained and kept reasonably accessible. First aid kits must be on hand during recess, physical education classes, and extracurricular activities.

If a situation occurs at school in which a person could have been exposed to an infectious agent, such as an instance of blood-to-blood contact, school authorities should counsel that person (or, if a minor, alert a parent or guardian) to seek an appropriate medical evaluation. It is not necessary for school authorities to request confidential health information about the other person, because the medical evaluation should consider the possible transmission of a variety of pathogens including HIV, hepatitis, and others.

Drugs and food supplements

Anabolic steroids are drugs that effectively build muscle mass and are therefore attractive to some athletes and other young people who want to enhance their physical appearance. Although it is derived from a male sex hormone, the drug can shut down the healthy functioning of the male reproductive system.[76] Females may experience "masculinization" as well as other problems. Continued use of anabolic steroids may lead to health conditions ranging from merely irritating to life threatening, and they can halt growth prematurely in adolescents. In addition, if needles are shared, users run the risk of transmitting or contracting a blood-borne pathogen such as HIV. School staff, and coaches in particular, need to send a strong and consistent message against the use of these powerful and dangerous drugs.

Although the case against legal dietary supplements is not as clear cut, both NFHS and the NCAA urge that coaches and other school staff refrain from advising students to use dietary supplements. Possession of these substances on school grounds should be treated like medications that require written parental approval.

Nutritional Supplements

Nutritional supplements are marketed to athletes to improve performance, recovery time required after a workout, or to build muscles. Many athletes use nutritional supplements despite their having been proven ineffective. In addition such substances are expensive and may be harmful to health or performance.

- Protein and amino acid supplements are popular with body-builders and strength-training athletes. Although protein is needed to repair and build muscles after strenuous training, most studies have shown that athletes ingest a sufficient amount without supplements.
- Although selected amino acid supplements are purported to increase growth hormone, studies using manufacturer-recommended amounts have not found an increase in growth hormone and muscle mass. Ingesting high amounts of single amino acids is contraindicated because they can affect the absorption of other essential amino acids and produce nausea or impair both training and performance.
- Other commonly advertised supplements are vitamins and minerals. Most scientific evidence shows that selected vitamins and minerals will not enhance performance. Other substances naturally occurring in foods, such as carnitine, herbal extracts, and special enzyme formulations, do not provide any benefit to performance.
- Creatine has been found in some laboratory studies to enhance short-term, high-intensity exercise capability, delay fatigue on repeated bouts of such exercise, and increase strength. Several studies have contradicted these claims, and, moreover, the safety of creatine supplements has not been verified.

Ultimately, most nutritional supplements are ineffective, costly, and unnecessary. A high-carbohydrate diet consisting of complex carbohydrates, five servings of fruits and vegetables a day, low-fat dairy products, adequate protein, and whole grains is the optimal diet for peak performance.

Athletics departments and athletes also should be concerned about "nutritional" supplements from another perspective. Many compounds obtained from specialty "nutrition" stores and from mail order businesses may not be subject to the strict regulations set by the U.S. Food and Drug Administration (FDA). Therefore, contents of many of these compounds are not represented accurately on the list of ingredients and may contain impurities or banned substances which may cause a student-athlete to test positive.

Athletes depend on coaches and athletic trainers to supply them with accurate and sound information on sports nutrition and help them discern media hype from fact about supplements. Given the above information, athletics administrators should evaluate the appropriateness of athletics department staff distributing or endorsing "nutritional" supplements.

—National Collegiate Athletic Association[77]

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Resources

- Policymakers and administrators may want to consult with legal counselors who are familiar with education law concerning liability for athletic and other co-curricular activities. Your state education department, state school boards association, and state high school activities association might be able to provide detailed guidance and assistance.

- **The National Association for Sport and Physical Education** (NASPE) offers a number of useful resources, including:

  - *Principles of Safety in Physical Education and Sport;*
  - *Checklist for Safety in Sports;* and
  - *Liability and Safety in Physical Education and Sport: A Practitioner's Guide to the Legal Aspects of Teaching and Coaching in the Elementary and Secondary Schools.*

  For information call (703) 476-3410, (800) 213-7193 x410, or go to www.aahperd.org/naspe. To order resources call (800) 321-0789.

- **The National Program for Playground Safety** (NPPS) serves as a national clearinghouse for playground safety information; conducts ongoing research in the area of injury prevention; and houses a large compilation of playground-related publications and documents, including an inspection guide and state-by-state report cards. NPPS also has developed a national action plan that outlines specific steps that state and local officials can implement. Call (800) 554-PLAY or go to www.uni.edu/playground.

- The **Children's Safety Network**, a group of four resource centers funded by the U.S. Maternal and Child Health Bureau, publishes *Injuries in the School Environment: A Resource Guide* and provides other information, training, and technical assistance on injury prevention and how to teach basic emergency life support skills to students. Call the Education Development Center at (617) 969-7100 or go to www.edc.org/HHD/csn.

- The **U.S. Consumer Products Safety Commission** (CPSC) has issued guidelines for inspection and maintenance of playgrounds and their equipment. CPSC's publications, available on the Internet at www.cpsc.gov, include the *Handbook for Public Playground Safety*, the *Public Playground Safety Checklist*, and *Tips for Public Playground Safety.* They also operate a site oriented toward young people at www.cpsc.gov/kids/kidsafety.

- *Playing It Safe: A Fourth Nationwide Safety Survey of Public Playgrounds* was released in June 1998 by the **U.S. Public Interest Research Group** (PIRG) and the **Consumer Federation of America** (CFA). Copies of the report can be ordered by calling PIRG at (202) 546-9707. Much of it is on the Internet at www.pirg.org. Also available is a "Model law on public play equipment and areas" that states, school districts, and schools might want to consider.

- Current injury statistics are available from the **National Center for Injury Prevention and Control** (NCIPC), part of the CDC, at www.cdc.gov/ncipc/osp/data.htm.

- The **National Playground Safety Institute** (NPSI) at the National Recreation and Park Association (NRPA) has a number of publications concerning playground safety and offers a course to become a Certified Playground Safety Inspector. Call (703) 858-2190 or go to www.nrpa.org/playsafe/playsafe.htm.

- The *Yearbook of Youth Sports Safety* is a collection of reports compiled by the **National Youth Sports Safety Foundation**. The reports were submitted from national medical and sports organizations and feature their efforts to address areas of concern in youth sports safety. Included are position papers or official statements, injury and participation statistics, rule changes, participation requirements and recommendations, safety equipment and facility recommendations, conference proceedings, publications and resources, educational safety programs and campaigns, and coaching education programs or requirements. Phone (617) 277-1171 or order at www.nyssf.org.

- The *Legal Handbook on School Athletics* from the **National School Boards Association** addresses legal issues concerning tort liability, insurance, and various ways of minimizing a school district's liability for injuries. Call (703) 838-6722.
- *Occupational Exposure to Blood-Borne Pathogens: Implementing OSHA Standards in School Settings* is available from the **National Association of School Nurses** (NASN) at (207) 883-2117. This guide includes sample policies, forms, and checklists.
- Your local chapter of the **American Red Cross** is a good resource for training in first aid and infection control.
- Infection control personnel in local hospitals or emergency medical services programs also might be able to offer assistance in policy development and/or training.
- The **American Cancer Society** has information on skin cancer prevention at www2.cancer.org/skinGuide.
- The **Office of Dietary Supplements** at the National Institutes of Health offers public access to credible, scientific literature on vitamins, minerals, and herbal and botanical supplements. Call (301) 435-2920 or go to http://odp.od.nih.gov/ods.
- The *1998-99 NCAA Sports Medicine Handbook* from the **National Collegiate Athletic Association** can be downloaded at www.ncaa.org/sports_sciences/sports_med_handbook.

Appendix: HIV, AIDS, and School Athletics

This appendix is adapted from *Someone at School has AIDS: A Complete Guide to Education Policies Concerning HIV Infection* (1996) by the National Association of State Boards of Education.

To date, there has been no known case of HIV transmission in a school, day care center, or school athletic setting. The evidence is strong that the risk of HIV infection is extremely low when current guidelines are followed.

Many people are particularly worried about HIV transmission in school sports programs. Although cuts, abrasions, and nosebleeds can be fairly common on the mat or playing field, rigorous studies consistently conclude that the potential risk of infection during competition is extremely low.[7,8] Nearly 20 years into the epidemic, there is still no confirmed case of HIV transmission during an athletic activity.

Healthy skin is a trustworthy barrier against infection by HIV, the virus that causes AIDS. A wound, abrasion, or seriously chapped area could theoretically allow HIV transmission, but only if an adequate amount of infected blood succeeds in passing through the skin break. The necessary amount of an infected person's blood is not likely to enter another person's body during competition, even during a hard-charging contact sport.

Furthermore, everyday casual contact with a person with HIV infection carries no risk of viral transmission. Sweat does not contain HIV, nor is it expelled in a cough or sneeze. Minute quantities of virus particles are sometimes detected in tears or saliva, but contact with these fluids has never been shown to result in HIV transmission.

Participation must be allowed

There is no medical reason to automatically disallow a student or school staff member with HIV infection to participate in recess, physical education, or a school athletic program if he or she wants and is able to do so. Doctors often recommend moderate exercise for people with HIV infection. Professional athletes have demonstrated that people infected with HIV can perform at full capacity. With the help of a physician and family members, a person living with HIV infection should be the one to decide whether his or her health status allows participation in athletic activities.

In fact, disallowing participation in any school-sponsored activity primarily on the basis of HIV infection violates federal civil rights laws, notably the Americans with Disabilities Act (ADA). This includes physical education classes, intramural programs, competitive sports, and recess. School authorities should determine how to satisfy the individual needs of a student on a case-by-case basis by following established policies and procedures for students with chronic health problems or other disabling conditions, processes that have long been required by federal law.

A special procedure to assess the situation of each student with HIV infection, ill or not, is not necessary. There is nothing unique about HIV infection that existing procedures cannot address.

Similarly, the right of an athletic staff member who is living with HIV infection or AIDS to keep his or her job is also protected by the ADA, as long as the employee can continue to fulfill the "essential functions" of the job with "reasonable accommodations." This also applies to volunteer athletic aides.

Athletic program guidelines

NFHS offers specific model rules about bleeding for 12 common school sports, including timeouts, substitutions, reintroduction, etc. These should be added to rulebooks everywhere. Teams should practice an "infection control game plan" so that procedures, roles, and responsibilities are clear to one and all.

On Testing Athletes for HIV

Routine HIV testing of all athletes is unnecessary, impractical, unmanageable, and costly for many reasons.

—CDC National AIDS Clearinghouse

There is no medical or public health justification for testing or screening for HIV infection prior to participation in sports activities.

—World Health Organization

Most state school athletic associations do not allow game cancellations due to fear of AIDS— a team that refuses to play another team for this reason forfeits the contest. The principal risks faced by athletes are related to their *off*-the-field activities.

Resources

- *Someone at School has AIDS: A Complete Guide to Education Policies Concerning HIV Infection* (1996) can be ordered from the **National Association of State Boards of Education** at (800) 220-5183.
- The **CDC National Prevention Information Network** (incorporating the former CDC National AIDS Clearinghouse) has a number of resources available that address HIV infection and athletics. Call (800) 458-5231 or go to www.cdcnpin.org.
- *Pediatric HIV Infection: A Compendium of AAP Guidelines* from the **American Academy of Pediatrics** includes policy statements developed by an ongoing task force on HIV and athletics. Call (800) 433-9016.
- Your state high school activities association should be a good source of information on athletic programs and training programs for athletic department staff.
- Call the **National Federation of State High School Associations** (NFHS) at (816) 464-5400 for information on revising sports rules to incorporate infection control guidelines.

References

[1] Seefeldt, V., "Physical Education," in Marx, E. and Wooley, S.F., *Health Is Academic: A Guide to Coordinated School Health Programs*, New York: Teachers College Press, 1998, page 116.

[2] U.S. Department of Health and Human Services, *Physical Activity and Health: A Report of the Surgeon General*, 1996.

[3] Centers for Disease Control and Prevention, "Guidelines for school and community programs to promote lifelong physical activity among young people," *MMWR*, March 7, 1997, Vol. 46, No. RR-6.

[4] Pate, R. et al., "Associations between physical activity and other health behaviors in a representative sample of U.S. adolescents," *American Journal of Public Health*, 1996; 86: 1577–1581.

[5] Jensen, E., *Teaching with the Brain in Mind*, Association for Supervision and Curriculum Development, Alexandria, VA, 1998.

[6] Centers for Disease Control and Prevention, "Update: Prevalence of overweight among children, adolescents, and adults— United States, 1997," *MMWR*, March 7, 1998, Vol. 47, No. SS-3.

[7] Fagot-Campagna, A. et al., "Type 2 diabetes among North American children and adolescents: an epidemiological review and a public health perspective," *Journal of Pediatrics* (submitted).

[8] Pinas-Hamiel, O. et al., "Increased incidence of non-insulin-dependent diabetes mellitus among adolescents," *Journal of Pediatrics*, 1996; 128: 608–615.

[9] Koop, C.E., "Shape Up America 1996 Annual Report, Message from the Chairman." Available at www.shapeup.org/general/96annual/01.htm.

[10] Centers for Disease Control and Prevention, "Youth risk behavior surveillance— United States, 1997," *MMWR*, August 14, 1998, Vol. 47, No. SS-3.

[11] McGinnis, J.M. and Foege, W.H., "Actual causes of death in the United States," *JAMA*, 1993; 270(18): 2207–2212.

[12] National Heart, Lung, and Blood Institute, "Report of the expert panel on blood cholesterol levels in children and adolescents," Bethesda, MD: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, 1991. NIH publication no. 91-2732.

[13] Bunker, L., "Psycho-physiological contributions of physical activity and sports for girls," *Research Digest*, President's Council on Physical Fitness and Sports, 1998; 3(1).

[14] Stone, E.J. et al., "Effects of physical activity interventions in youth: review and synthesis," *American Journal of Preventive Medicine*, 1998; 15(4): 298–315.

[15] Adams, P.F. et al., "Health-risk behaviors among our nation's youth: United States, 1992," *Vital Health Statistics*, National Center for Health Statistics, 1995, 10(192). DHHS publication no. (PHS) 95-1520.

[16] Corbin, C. and Pangrazi, B., *Physical Activity for Children: A Statement of Guidelines*, Council on Physical Education for Children, National Association for Sport and Physical Education, 1998.

[17] Sallis, J.F. and Patrick, K., "Physical activity guidelines for adolescents: Consensus statement," *Pediatric Exercise Science*, 1994; 6(4): 302–314.

[18] National Association for Sport and Physical Education, *Speak II, Physical Education Advocacy Kit II*, 1999.

[19] U.S. Department of Health and Human Services, "National Children and Youth Fitness Study," *Journal of Physical Education, Recreation, and Dance*, 1985; 56: 44–90.

[20] Centers for Disease Control and Prevention, "Fact Sheet: Youth risk behavior trends from CDC's 1991, 1993, 1995, and 1997 YRBS surveys," Atlanta, GA: U.S. Department of Health and Human Services, 1999.

[21] Centers for Disease Control and Prevention, unpublished data from the School Health Policies and Programs Study, 1994.

[22] Pate, R. et al., "School physical education," *Journal of School Health*, 1995; 65(8): 313–315.

[23] National Association for Sport and Physical Education, *Shape of the Nation Report: A Survey of State Physical Education Requirements*, January 1997.

[24] National Association for Sport and Physical Education, *Moving into the Future: National Standards for Physical Education*, Mosby Year-Book, Inc., 1995.

[25] California Department of Education, *Physical Education Framework for California Public Schools Kindergarten Through Grade Twelve*, 1994, p. 8–9.

[26] Pate, R. et al., "School physical education," *Journal of School Health*, 1995; 65(8): 313–318.

[27] Arizona Department of Education, policy dated April 28, 1997.

[28] *Health Psychology*, 1999; 18: 410–15.

[29] *Reuters Health News Service*, "Fun physical education classes lead to active kids,"www.intelihealth.com, July 12, 1999.

[30] *The Washington Post*, "Guidelines aim to boost children's exercise," June 2, 1997, Health section, p.11.

[31] McKenzie, T.L et al., "School physical education: Effect of the Child and Adolescent Trial for Cardiovascular Health (CATCH)," *Preventive Medicine*, 1996; 25: 423–431.

[32] Sallis, J.F. et al., "The effects of a two-year physical education program (SPARK) on physical activity and fitness in elementary school students," *American Journal of Public Health*, 1997; 87: 1328–1334.

[33] Simons-Morton, B.G. et al., "Observed levels of elementary and middle school children's physical activity during physical education classes," *Preventive Medicine*, 1994; 23: 437–441.

[34] McKenzie and Sallis papers cited ibid, plus: Simons-Morton, B.G. et al., "Promoting physical activity and a healthful diet among children: Results of a school-based intervention study," *American Journal of Public Health*, 1991; 81: 986–991.

[35] Meyer, M., "The new P.E.," *Better Homes and Gardens*, November 1997: 108-110.

[36] Horseheads Central School District, New York, undated policy.

[37] National Federation of State High School Associations, "The case for high school activities," undated. Available at www.nfhs.org.

[38] Carlton, P. and Stinson, R., "Achieving educational goals through intramurals," *Journal of Physical Education, Recreation, and Dance*, 1993: 23–26.

[39] Ewing, M.E. et al., "Role of organized sport in the education and health of American children and youth," East Lansing, MI: Institute for the Study of Youth Sports, Michigan State University, 1996.

[40] "Stilwell Junior High Intramural Program," in Sammann, P., *Active Youth*, Champaign, IL: Human Kinetics, 1998.

[41] National Association of State Boards of Education, "No pass, no play: Eligibility requirements for extracurricular activities," *NASBE Policy Update*, June 1999.

[42] California School Boards Association, Sample Administrative Regulation, AP 6145.21(a), 1990.

[43] National Association of State Boards of Education, *Someone at School has AIDS: A Complete Guide to Education Policies Concerning HIV Infection*, 1996.

[44] U.S. Department of Education, *Title IX 25 Years of Progress*, June 1997. Available at www.ed.gov/pubs/TitleIX.

[45] Kelly, C.L., "Participation in athletic programs: Clearing the Title IX and equal protection hurdles," *Legal Handbook on School Athletics*, 1997, National Schools Boards Association, Alexandria, VA, p. 5-1–5-12.

[46] Office for Civil Rights, "Student assignment in elementary and secondary schools and Title IX," U.S. Department of Education, 1991. Available at www.ed.gov/offices/OCR.

[47] Gessford, J. and Perry, G., "Athletic personnel and volunteer issues," *Legal Handbook on School Athletics*, 1997, National Schools Boards Association, Alexandria, VA, p. 10–8.

[48] Ross, J.G. et al., "What is going on in the elementary physical education program?" *Journal of Physical Education, Recreation, and Dance*, 1987: 78–84.

[49] Johnson, D., "Trend toward no-recess policy is accelerating in the nation's schools," *New York Times*, April 7, 1998.

[50] "More schools are giving kids a break from recess," *Education Daily*, December 31, 1998; 31(246): 1,5–6.

[51] National Association for Sport and Physical Education, "NASPE tells parents and elementary school officials 'Recess is a must!'," press release, Reston, VA, November 2, 1998.

[52] National Association of Elementary School Principals, "NAESP Platform 1999–2000," Alexandria, VA: p. 12.

[53] "All work and no play..." *NAESP Communicator,* 1999; 22(5): 1.

[54] Adapted from "The case for elementary school recess," American Association for the Child's Right to Play, undated, available at www.ipausa.org/recess.htm.

[55] Klesges, R.C. et al., "Effects of obesity, social interactions, and physical environment on physical activity in preschoolers," *Health Psychology,* 1990; 9: 435–449.

[56] Sallis, J.F. et al., "Correlates of physical activity at home in Mexican-American and Anglo-American pre-school children," *Health Psychology,* 1993; 12: 390–398.

[57] Pellegrini, A.D. and Smith, P.K., "School recess: Implications for education and development," *Review of Educational Research,* 1993; 63(1): 51–67.

[58] Pellegrini, A.D. and Davis, P.D., "Relations between children's playground and classroom behaviour," *British Journal of Educational Psychology,* 1993; 63: 88–95.

[59] Jarrett, O.S., "Effect of recess on classroom behavior: Group effects and individual differences," *Journal of Education Research,* 1998; 92(2): 121–126.

[60] Smith, T.R., "Play first, eat last," *School Foodservice Journal,* 1980: 54–55.

[61] Ruppenthal, B. and Hogue, W., "Playground and plate waste," *School Foodservice Journal,* 1977: 66–70.

[62] Sammann, P., "Clay Organized for Wellness," in *Active Youth: Ideas for Implementing CDC Physical Activity Promotion Guidelines,* Human Kinetics, 1998.

[63] Sammann, P., "Clovis High School Program," in *Active Youth: Ideas for Implementing CDC Physical Activity Promotion Guidelines,* Human Kinetics, 1998.

[64] Blair, S.N. et al., "Health promotion for educators: Effect on health behaviors, satisfaction, and general well-being," *American Journal of Public Health,* 1984; 74: 147–149.

[65] Allegrante, J.P. and Michela, J.L., "Effect of a school-based workplace health promotion program on morale of inner-city teachers," *Journal of School Health,* 1990; 60: 25–28.

[66] Allegrante, J.P., "School-site health promotion for staff." In Marx, E. and Wooley, S.F., *Health Is Academic: A Guide to Coordinated School Health Programs,* New York: Teachers College Press, 1998, p. 224–243.

[67] Bannock School District, Idaho, policy dated 1989.

[68] Northcart, M. and Willmes, C., "Student injuries during physical education classes and extracurricular athletic activities: A survey of potential tort liability of public school activities." *Legal Handbook on School Athletics,* 1997, National Schools Boards Association, Alexandria, VA, p. 7-4–7-5.

[69] Moyer, J., "Spectator issues in public school athletics," *Legal Handbook on School Athletics,* 1997, National Schools Boards Association, Alexandria, VA, p. 8-2.

[70] U.S. Consumer Product Safety Commission, "KaBoom! Is your public playground a safe place to play?" This can be downloaded at www.cpsc.gov/cpscpub/pubs/pg1.pdf.

[71] National Center for Injury Prevention and Control, "Playground Injuries Fact Sheet," October 1997, available at www.cdc.gov/ncipc/duip/playgr.htm.

[72] DiScala C. et al., "Causes and outcomes of pediatric injuries occurring at school," *Journal of School Health,* 1997; 67(9): 384–389.

[73] Elwood, J.M. and Gallagher, R.P., "Sun exposure and the epidemiology of melanoma." In Gallagher, R.P. and Elwood, J.M., *Epidemiological Aspects of Cutaneous Malignant Melanoma,* Kluwer Academic Publishers, Boston, 1994; 15–66.

[74] Weinstock, M.A. et al., "Nonfamilial cutaneous melanoma incidence in women associated with sun exposure before 20 years of age," *Pediatrics,* 1989; 84(2): 199–204.

[75] National Federation of State High School Associations, "NFHS Addresses Food Supplements," press release, August 10, 1998. Available at www.nfhs.org/PR-supplements.htm.

[76] National Institute on Drug Abuse, *Anabolic Steroids: A Threat to Mind and Body,* undated. DHHS Publication No. (ADM) 91-1810. Available from the National Clearinghouse on Alcohol and Drug Information (NCADI), (800) 729-6686, or at www.nida.nih.gov/ResearchReports/Steroids.

[77] National Collegiate Athletic Association, "Guideline 2-J: Nutritional Ergogenic Aids," revised July 1997, *1998-99 NCAA Sports Medicine Handbook*, p. 36–37.

[78] CDC National AIDS Clearinghouse, "Locating Information about HIV/AIDS and Sports," 1995.

E. Policies to Encourage Healthy Eating

Schools can— and inevitably do— play a powerful role in influencing students' dietary behaviors. There are several ways that schools can help ensure that the daily eating habits being formed by young people will contribute to their learning achievement and lifelong good health:

- nutrition education can equip students with the knowledge, skills, and motivation that provide a foundation for a lifetime of healthy eating;
- the school food service program can provide opportunities for students to practice healthy eating on a daily basis— more than one-half of young people in the United States get one of three major meals from school meal programs, and 10 percent gets two of their three main meals at school;[2] and
- schools can encourage healthy eating habits in the ways they manage other food choices available at school outside of the cafeteria, e.g., vending machines, snack bars, school stores, concession stands, parties, and meetings.

To Do Well in School

> Healthful diets help children grow, develop, and do well in school. They enable people of all ages to work productively and feel their best.
>
> —U.S. Department of Agriculture and U.S. Department of Health and Human Services[1]

This chapter provides guidance on developing a comprehensive, integrated policy aimed at promoting lifelong healthy eating among students and school staff. The sample policy addresses all aspects of the school setting that influence a person's eating patterns. The policy:

- defines the purpose and goals of the school nutrition policies;
- establishes principles to guide the delivery of nutrition education, the food service program, and school-based services for students with nutrition-related health problems; and
- enumerates standards for all food and beverages to be served or sold at school and the conditions under which they are served or sold.
- The sample policy on healthy eating incorporates statements of recommended practice that all states, districts, and schools should endeavor to adopt. What is reason-able, feasible, and acceptable in a given state, school district, or school depends on local circumstances and the results of the policymaking process.

Adopting sound policy is just a start. A comprehensive policy is more likely to be smoothly implemented and consistently enforced if it receives strong administrative support and if all staff become oriented to the policy and the rationale behind it. These actions can convey the importance of nutrition issues to staff and encourage them to promote healthy eating habits in their interactions with students.

The sample policy is divided into five parts as listed below. A discussion section that provides supportive information and a list of key resources follows each part of the policy.

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2. Nutrition Education E-11
3. The Food Service Program E-17
4. Other Food Choices at School E-27
5. Services for Nutrition-Related Health Problems E-37

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1. Purpose and Goals

A strong statement of purpose and goals provides a firm foundation for a sound policy. It justifies the policy to staff and the public, communicates policymakers' priorities, and helps guide program implementation.

Healthy Eating Sample Policy, Part One:

INTENT. All students shall possess the knowledge and skills necessary to make nutritious and enjoyable food choices for a lifetime. In addition, staff are encouraged to model healthy eating as a valuable part of daily life. School leaders shall prepare, adopt, and implement a comprehensive plan to encourage healthy eating that includes:

- a food service program that employs well-prepared staff who efficiently serve appealing choices of nutritious foods;
- pleasant eating areas for students and staff with adequate time for unhurried eating;
- a sequential program of nutrition instruction that is integrated within the comprehensive school health education curriculum and coordinated with the food service program; that is taught by well-prepared and well-supported staff; and that is aimed at influencing students' knowledge, attitudes, and eating habits;
- an overall school environment that encourages students to make healthy food choices;
- opportunities and encouragement for staff to model healthy eating habits;
- services to ensure that students and staff with nutrition-related health problems are referred to appropriate services for counseling or medical treatment; and
- strategies to involve family members in program development and implementation.

The school nutrition program shall make effective use of school and community resources and equitably serve the needs and interests of all students and staff, taking into consideration differences in cultural norms.

RATIONALE. The link between nutrition and learning is well documented. Healthy eating patterns are essential for students to achieve their full academic potential, full physical and mental growth, and lifelong health and well-being. Healthy eating is demonstrably linked to reduced risk for mortality and development of many chronic diseases as adults. Schools have a responsibility to help students and staff establish and maintain lifelong, healthy eating patterns. Well-planned and well-implemented school nutrition programs have been shown to positively influence students' eating habits.

DEFINITIONS. For the purposes of this policy:

"Competitive foods" refers to any foods or drinks sold or served on school grounds other than U.S. Department of Agriculture (USDA)-reimbursable school lunches, school breakfasts, and after-school snacks.

"Dietary Guidelines for Americans" refers to the current set of recommendations of the federal government that are designed to help people choose diets that will meet nutrient requirements, promote health, support active lives, and reduce chronic disease risks.

"Nutrition education" refers to a planned sequential instructional program that provides knowledge and teaches skills to help students adopt and maintain lifelong healthy eating patterns.

Discussion

Unfortunately, most young people in the United States are not meeting recommendations for a healthy diet. For example:

- 64 percent of young people ages 6–17 eat too much total fat, and 68 percent eat too much saturated fat;[3]
- only 18 percent of young people ages 6–17 eat five servings of fruits and vegetables a day (excluding fried potatoes and chips);[3]
- only 18 percent of girls ages 9–19 consume enough calcium;[4] and
- of children ages 6–11, 84 percent of boys and 74 percent of girls consume too much sodium; of adolescents ages 12–19, 96 percent of boys and 71 percent of girls consume too much sodium.[4]

Schools have an important responsibility to play an active role in promoting healthy eating, for four broad reasons:

1. Alleviating hunger

School food service programs can help alleviate hunger by providing students with a major portion of their food intake. A recent survey conducted by the U.S. Bureau of the Census found that about 10.5 million U.S. households (10.2 percent of all households) were "food insecure" during the 12 months ending in August 1998, meaning that they did not have enough food to fully meet basic needs at all times. Among these, 3.7 million reached a level of severity great enough that one or more household members had experienced hunger due to inadequate resources. Some 3.4 million children lived in such households.[5]

/

Nutrition and Cognitive Development

- Undernutrition along with environmental factors associated with poverty can permanently affect physical growth, brain development, and cognitive functioning.
- The longer a child's nutritional, emotional, and educational needs go unmet, the greater the likelihood of cognitive impairments.
- Iron deficiency anemia is associated with impaired cognitive development.
- Supplemental feeding programs can help to offset threats posed to the child's capacity to learn and perform in school, [threats that] result from inadequate nutrient intake.

—Tufts University Center on Hunger, Poverty, and Nutrition Policy[7]

Another nationwide survey found that "food insufficiency" (an inadequate amount of food intake due to lack of resources) is not limited to persons of low income, specific racial/ethnic groups, or certain family types.[6] The survey found that more than half (54 percent) of food-insufficient individuals lived in families where the family head was employed.

2. Ensuring the necessary foundation for learning

Studies have shown that chronically undernourished children earn lower scores on standardized achievement tests, especially tests of language ability.[8,9] They are also more likely than other children to become sick, to miss school, and to fall behind in class. Undernourished students are often irritable, have difficulty concentrating, and have low energy.[8]

Research also shows that children from families that report multiple experiences of food insufficiency and hunger are more likely to show behavioral problems (such as hyperactivity and aggression), emotional problems (such as anxiety), and academic problems (such as absences and tardiness) than children from the same low-income communities whose families did not report experiences of hunger.[10,11]

Another research finding is that skipping breakfast can adversely affect children's performance in problem-solving tasks.[13] Studies of low-income elementary school students have found that those who participated in the federal School Breakfast

The Importance of Calcium

By age 17, almost 91 percent of the adult skeletal volume is formed, and since bones are comprised mostly of calcium, phosphorus, and protein, sufficient calcium intake during adolescence is paramount to successfully achieving this rapid growth.... Available data indicate that girls are able to absorb the most calcium near the onset of [puberty], and then this capability declines for the rest of their lives....

Osteoporosis [a disease in which the bones become extremely porous, are subject to fracture, and heal slowly, occurring especially in women following menopause and often leading to curvature of the spine from vertebral collapse] has been referred to as "a pediatric disease with geriatric consequences." Since it is easier to prevent osteoporosis than it is to treat it, it is important to act now.

—Denise Amschler[12]

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Program had greater improvements in standardized test scores and math grades, and reduced rates of absence, tardiness, and psychosocial problems, than children who qualified for the program but did not participate.[13,14]

3. Preventing premature deaths

A poor diet and physical inactivity together account for at least 300,000 deaths among adults in the United States each year—only tobacco use contributes to more deaths.[15] Diet is a known risk factor for development of the nation's three leading causes of death: coronary heart disease, cancer, and stroke.[16,17]

Other serious health problems of adulthood that are associated with a poor diet include diabetes, high blood pressure, obesity, and osteoporosis[16] (see box, "The Importance of Calcium," on the preceding page).

4. Preventing health problems in youth

Unhealthy eating habits can also lead to serious problems during childhood and adolescence, including iron-deficiency anemia, obesity, and unsafe weight loss methods.

Anemia

Iron deficiency is one of the most prevalent nutritional problems of children in the United States. Iron deficiency in infancy may cause a permanent loss of IQ later in life. Iron deficiency and anemia lead to shortened attention span, irritability, fatigue, and difficulty with concentration. Consequently, anemic children tend to do poorly on vocabulary, reading, and other tests.

—National Health/Education Consortium[18]

The unhealthy eating habits that contribute to these health problems tend to be established early in life.[19] Indeed, some of the physiological processes that lead to diet-related chronic disease begin in childhood. For example, early indicators of atherosclerosis, the hardening of the arteries that is the most common cause of coronary heart disease, begin in youth and are related to blood cholesterol levels in young persons.[19]

Of particular concern is obesity, which has increased dramatically in recent years. The percentage of young Americans ages 6–17 who are overweight has nearly tripled since the 1960s, from four to eleven percent.[21] Obesity in young persons is related to

Literally Growing before Our Eyes

Obesity and overweightness affect 10 million U.S. children. That's a record, and there's no real sign that it won't be broken again soon. In the past 20 years, the number of obese children has doubled, placing more Americans at risk of high cholesterol, high blood pressure, heart disease, diabetes, arthritis, and cancer—all at an earlier age. Obesity contributes to 300,000 deaths each year. That's close to 1,000 lives lost each day at a cost to our health care system of $70 billion a year, or eight percent of all medical bills.

We need to take this issue seriously. For at least one in five kids, overweightness is not a cute phase that will be outgrown. It's the start of a lifetime of serious health problems. It is time we elevate this issue to its rightful place near the top of the public health agenda alongside cancer, heart disease, and other leading killers of Americans today.

—U.S. Secretary of Agriculture Dan Glickman[20]

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elevated blood cholesterol levels, high blood pressure, psychological stress, and increased adult mortality.[19] Increasing rates of obesity might be contributing to a sharp increase in pediatric cases of Type 2 diabetes that doctors have reported in recent years.[22,23] Type 2 is commonly referred to as "adult-onset" diabetes, but increasingly the disease is being seen in young people.

Yet at the same time the nation is experiencing this "epidemic of obesity,"[24] a great many young people practice unsafe weight-loss methods. For example, a 1997 national survey found that 13 percent of female high school students induced vomiting after meals or used laxatives or diet pills to control their weight.[25]

Attention also needs to be paid to eating disorders, such as anorexia nervosa and bulimia nervosa, which are psychological disorders characterized by severe disturbances in eating behavior. Eating disorders can cause many severe complications, including death. These disorders often start in adolescence and affect as many as three percent of adolescent and young adult females.[26]

Guidelines from CDC

Based on the available scientific literature, national nutrition policy documents, and current practice, CDC's *Guidelines for School Health Programs to Promote Healthy Eating* provide seven broad recommendations for ensuring a quality nutrition program within a comprehensive school health program:

POLICY: Adopt a coordinated school nutrition policy that promotes healthy eating through classroom lessons and a supportive school environment.

CURRICULUM FOR NUTRITION EDUCATION: Implement nutrition education from preschool through secondary school as part of a sequential, comprehensive school health education curriculum designed to help students adopt healthy eating behaviors.

INSTRUCTION FOR STUDENTS: Provide nutrition education through developmentally appropriate, culturally relevant, fun, participatory activities that involve social learning strategies.

INTEGRATION OF SCHOOL FOOD SERVICE AND NUTRITION EDUCATION: Coordinate school food service with nutrition education and with other components of the comprehensive school health program to reinforce messages on healthy eating.

TRAINING FOR SCHOOL STAFF: Provide staff involved in nutrition education with adequate preservice and ongoing in-service training that focuses on teaching strategies for behavioral change.

FAMILY AND COMMUNITY INVOLVEMENT: Involve family members and the community in supporting and reinforcing nutrition education.

PROGRAM EVALUATION: Regularly evaluate the effectiveness of the school health program in promoting healthy eating and change the program as appropriate to increase its effectiveness.

—Centers for Disease Control and Prevention[19]

Resources

- Your state or local education agency or public health department might have data to assist in program planning or may offer other resources.

- The CDC **Division of Adolescent and School Health** (DASH) offers a variety of materials and support services for schools, including:

  - the *Guidelines for School Health Programs to Promote Lifelong Healthy Eating*, which provides the basis for this NASBE policy guide;

  - the *School Health Index for Physical Activity and Healthy Eating: A Self-Assessment and Planning Guide*, is a companion document to this policy guide that provides a practical, detailed checklist of the elements of exemplary nutrition and physical education programs that schools and districts can use for self-diagnosis; and

  - assistance in implementing the Youth Risk Behavior Survey (YRBS), a nationwide system for collecting data on youth behaviors. An easy-to-use CD-ROM of national and state summary data is available to examine youth risk behaviors and trends over time in six risk categories, including dietary behaviors.

  Write to: CDC Division of Adolescent and School Health, 4770 Buford Highway, NE, Mail Stop K-32, Atlanta, GA 30341-3717;
  telephone: (770) 488-3168;
  FAX (770) 488-3111;
  e-mail ccdinfo@cdc.gov; or
  go to www.cdc.gov/nccdphp/dash.

- The **National Association of State Boards of Education** (NASBE) and the **National School Boards Association** (NSBA) both operate school health resource databases that contain many sample policies. NASBE's database focuses on state-level policies, and NSBA has compiled a large number of school district policies and support documents. NSBA has also compiled excerpts from key documents and sample district policies in a *Healthy Eating 101* packet. Both organizations can provide up-to-date information on policy topics, information on people's experiences in implementing policies, consultation on specific policy issues, and referrals to other experts in the field.

  - Contact NASBE at (703) 684-4000 or boards@nasbe.org.

  - Contact NSBA at (703) 838-6722 or schoolhealth@nsba.org.

- The **American School Food Service Association** (ASFSA) offers numerous documents to help schools develop sound policy. *Keys to Excellence: Standards of Practice for Nutrition Integrity* is available from the ASFSA Emporium at (800) 728-0728.

  Additional materials, including *Creating Policy for Nutrition Integrity* and *Do You Have a NAC* [Nutrition Advisory Council] *for Nutrition Education?*, are available from the ASFSA home office at (800) 877-8822 or go to www.asfsa.org.

- The current edition of the *Dietary Guidelines for Americans* is available by calling (202) 418-2312. The document can be downloaded at www.usda.gov/cnpp/guide.htm.

- The U.S. Department of Agriculture's **Food and Nutrition Information Center** (FNIC) offers an extensive array of resource lists, including one on Nutrition and Learning. Call (301) 504-5719 or go to www.nal.usda.gov/fnic.

- The **Vermont Department of Education** has prepared the *Action Planning Booklet for Creating the Nutrition Component of Your Vermont Comprehensive School Health Plan,* which employs checklists and self-evaluation. Call (802) 828-5151.

- USDA's **Food and Nutrition Service** provides information on statutes and regulations governing school meal programs, as well as training and technical assistance for food service personnel, nutrition educators, other school staff, and community leaders involved in policymaking. Call (703) 305-2055 or go to www.fns.usda.gov/cnp.

- **SHAPE California** is a network of over 70 school districts in which child nutrition staff, teachers, school administrators, family, and the community work together to provide a consistent nutrition message in child nutrition programs, classrooms, and throughout the school environment. For information and resources go to www.ausd.k12.ca.us/shape.

- The **American Dietetic Association** (ADA) provides resources to nutrition professionals and the general public. Call (800) 877-1600 or go to www.eatright.org.

- Policymakers may want to consider the rationale for school food programs offered in "School-Based Nutrition Programs and Services," a joint position paper of the **American Dietetic Association** (ADA), the **Society for Nutrition Education** (SNE), and the **American School Food Service Association** (ASFSA). This document is available by calling (800) 877-1600, or it can be downloaded at www.eatright.org/school-based.html.

- The **Food Research and Action Center** (FRAC) is a nonprofit, nonpartisan research and public policy center working to improve public policies to eradicate hunger and undernutrition in the United States. FRAC provides resources for hunger and antipoverty projects. Call (202) 986-2200, or go to www.frac.org.

- The **American Heart Association** has information and advice on heart-healthy eating. Call (800) AHA-USA1 or go to www.americanheart.org.

- The **American Cancer Society** also has useful information on nutrition and diet. Call (800) ACS-2345 or go to www.cancer.org.

Note

The organizations included as resources in this guide offer a broad range of assistance, have a national scope, are easily accessed, have information or materials available at low or no cost, or offer specialized expertise. The lists are not exhaustive. Scores of other organizations provide high-quality assistance and advice to educators; hundreds of informative books and articles are available. Consider the resources listed here as starting points.

2. Nutrition Education

A sound policy emphasizes that the primary goal of nutrition education is to influence students' actual eating behaviors and not just to teach facts about foods.

Healthy Eating Sample Policy, Part Two:

INSTRUCTIONAL PROGRAM DESIGN. Nutrition education topics shall be integrated within the sequential, comprehensive health education program taught at every grade level, pre-kindergarten through twelfth. The nutrition education program shall focus on students' eating behaviors, be based on theories and methods proven effective by published research, and be consistent with the _state's/district's_ health education _standards/guidelines/framework_. Nutrition education shall be designed to help students learn:

- nutritional knowledge, including but not limited to the benefits of healthy eating, essential nutrients, nutritional deficiencies, principles of healthy weight management, the use and misuse of dietary supplements, and safe food preparation, handling, and storage;
- nutrition-related skills, including but not limited to planning a healthy meal, understanding and using food labels, and critically evaluating nutrition information, misinformation, and commercial food advertising; and
- how to assess one's personal eating habits, set goals for improvement, and achieve those goals.

Nutrition education instructional activities shall stress the appealing aspects of healthy eating and be participatory, developmentally appropriate, and enjoyable. The program shall engage families as partners in their children's education.

The school health council shall assess all nutrition education curricula and materials for accuracy, completeness, balance, and consistency with the _state's/district's_ educational goals and standards. Materials developed by food marketing boards or food corporations shall be examined for inappropriate commercial messages.

STAFF QUALIFICATIONS. Staff responsible for nutrition education shall be adequately prepared and regularly participate in professional development activities to effectively deliver the nutrition education program as planned. Preparation and professional development activities shall provide basic knowledge of nutrition, combined with skill practice in program-specific activities and instructional techniques and strategies designed to promote healthy eating habits.

EDUCATIONAL REINFORCEMENT. School personnel shall not offer food as a performance incentive or reward and shall not withhold food from students as punishment.

Nutrition instruction shall be closely coordinated with the food service program and other components of the school health program. Nutrition concepts shall be integrated into the instruction of other subject areas.

School instructional staff shall collaborate with agencies and groups conducting nutrition education in the community to send consistent messages to students and their families. Guest speakers invited to address students shall receive appropriate orientation to the relevant policies of *school/district*.

School staff are encouraged to cooperate with other agencies and community groups to provide opportunities for student volunteer work related to nutrition, such as assisting with food recovery efforts and preparing nutritious meals for house-bound people. School officials should also disseminate information to parents, students, and staff about community programs that offer nutrition assistance to families.

STAFF AS ROLE MODELS. School staff are encouraged to model healthy eating behaviors. Schools should offer wellness programs that include personalized instruction about healthy eating and physical activity.

Discussion

Research has found that nutrition education programs that focus on influencing students' actual eating behaviors are much more likely to help students adopt healthy eating habits than the traditional, fact-based approach.[27] As pointed out by Isobel Contento of Columbia University in a comprehensive review of nutrition education programs,

> Knowledge and behavior are poorly related, so that increased knowledge cannot be assumed to result in changed behaviors.... Nutrition education "works," in that it is a significant factor in improving dietary practices when behavioral change is set as the goal and the educational strategies employed are designed with that as a purpose.[27]

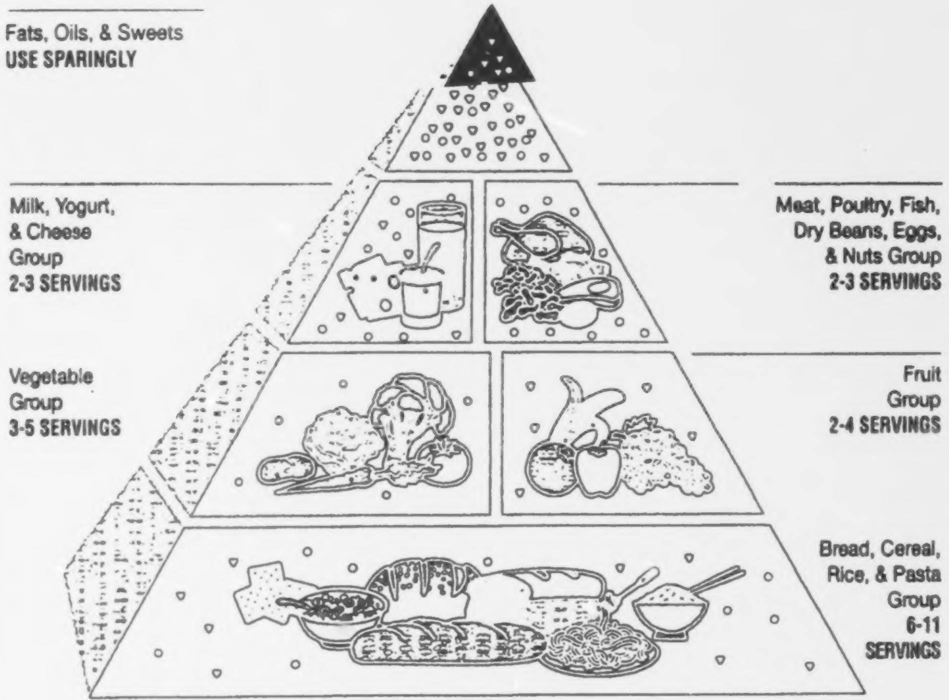
In other words, teachers need to go beyond lecturing about specific nutrients and should encourage students to explore the social, cultural, and personal influences on their own food choices. Lessons need to have personal meaning for students for them to be effective.

The "food guide pyramid" helps students gain an understanding of food choices, serving sizes, and dietary proportions (see Graphic 1 on the following page). Other suggestions for the scope and sequence of a sound nutrition education program can be gathered from your state department of education, the CDC guidelines, and numerous resource organizations.

Graphic 1

Food Guide Pyramid

A Guide to Daily Food Choices


Fats, Oils, & Sweets
USE SPARINGLY
Milk, Yogurt, & Cheese Group
2-3 SERVINGS
Meat, Poultry, Fish, Dry Beans, Eggs, & Nuts Group
2-3 SERVINGS
Vegetable Group
3-5 SERVINGS
Fruit Group
2-4 SERVINGS
Bread, Cereal, Rice, & Pasta Group
6-11 SERVINGS

SOURCE: U.S. Department of Agriculture/U.S. Department of Health and Human Services

Use the Food Guide Pyramid to help you eat better every day. . .the Dietary Guidelines way. Start with plenty of Breads, Cereals, Rice, and Pasta; Vegetables; and Fruits. Add two to three servings from the Milk group and two to three servings from the Meat group.

Each of these food groups provides some, but not all, of the nutrients you need. No one food group is more important than another — for good health you need them all. Go easy on fats, oils, and sweets, the foods in the small tip of the Pyramid.

To order a copy of *The Food Guide Pyramid* booklet, send a $1.00 check or money order made out to the Superintendent of Documents to: Consumer Information Center, Department 159-Y, Pueblo, Colorado 81009. The food guide pyramid is also available in a variety of formats from USDA's Food and Nutrition Information Center at www.nal.usda.gov/fnic.

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Teacher preparation

Effective teaching of health and nutrition education requires a body of knowledge and instructional skills that are uniquely different than the skills that are necessary to teach other subject areas. This is because health and nutrition classes aim to influence students' personal *behaviors* and not just to build their knowledge base and develop their cognitive skills. For example, self-assessment, goal setting, and resisting pressure from food advertisements are critical aspects of nutrition education that other teachers typically might not address.

Teachers need adequate preparation to teach nutrition skills effectively— they should not be expected to simply open a textbook and begin shaping students' behaviors. They also need ongoing support and continuous professional development. Yet a national survey found that in 1992-94 only 14 percent of teachers of health education in secondary schools had participated in in-service nutrition education training.[28] The predictable result was that only 40 percent were found to be teaching about the very important dietary guidelines for Americans; other shortcomings were also noted.[28]

Reinforcing nutrition lessons

With good coordination of effort, nutrition education teachers and school food service personnel can help each other attain their respective goals. For example, the school dining area can serve as a "nutrition laboratory" where students practice applying their understanding of nutrition. Offering a variety of nutritious food items allows students the chance to experiment with making their own food choices. Students should have opportunities to choose nutritious foods whenever and wherever food is available at school, e.g., from vending machines and snack bars.

To further connect school food services and nutrition education, food service personnel can be invited to make presentations and address students' questions in nutrition classrooms.

Nutrition education lessons need to be reinforced and supported throughout the school day. Nutrition topics can be infused into other subjects such as math, science, art, and social studies. For example, the role of private food company advertisements in public schools might be a good topic in civics classes. Science experiments can

Elements of Effectiveness

- **Nutrition education is more likely to be effective when it is behaviorally focused.**
- **Nutrition education interventions are more likely to be effective when they employ educational strategies that are directly relevant to a behavioral focus and are derived from appropriate theory and research.**
- **Interventions need to devote adequate time and intensity to nutrition education to be effective.**
- **Family involvement enhances the effectiveness of programs for younger children.**
- **Incorporation of a self-evaluation or self-assessment and feedback component is effective in interventions for older children.**
- **Effective nutrition education includes intervening in the school environment.**
- **Interventions in the larger community can enhance school nutrition education.**

—Isobel R. Contento[27]

directly measure the calorie content of various food items. Nevertheless, infusion of nutrition topics into other subject areas should not take the place of a planned, sequential nutrition education program delivered as part of a comprehensive school health education curriculum.

What Schools Can Accomplish

School-based nutrition programs and services, by promoting positive lifestyles and developing effective decision-making skills, offer the most systematic and efficient means available to improve the health of youth in America....

The ultimate goal of comprehensive school-based nutrition programs and services is to have students eating in a health-promoting manner. However, given the many factors influencing eating behavior, it is unrealistic to hold schools alone accountable for achieving this goal. On the other hand, it is appropriate to hold schools accountable for providing students with the behavioral skills, knowledge, and attitudes necessary to eat well and cope with potential threats to eating well.

—Position of the American Dietetic Association, the Society for Nutrition Education, and the American School Food Service Association[29]

The emphasis on environmental and behavioral factors in successful school-based nutrition interventions highlights the importance of involving parents and other community members. Parents are important role models for children, and they provide opportunities for children to practice healthful eating habits and reinforce these behaviors at home. Family involvement should be designed into every aspect of nutrition education.

Staff as role models

Role modeling is one of the most powerful influences on behavior, and school staff have the potential to be very powerful role models for students. Although schools cannot dictate the personal lifestyle behaviors of their staff, they can make it easier for staff to become nutrition role models by sponsoring school-site health promotion programs for staff. Teachers who become interested in their own health tend to take a greater interest in the health of their students and become more effective teachers of health.[30]

Evaluations have found that participation in school health promotion programs for staff can also increase morale, increase participation in vigorous activity, improve physical fitness, facilitate weight loss, lower blood pressure, and improve stress-management skills.[31,32]

The use of food as an incentive

Establishing healthy student attitudes toward eating requires that staff not use food as an incentive: either as a punishment (such as withholding treats other students are receiving) *or* as a reward. Research indicates that young children's food preference patterns are largely influenced by repeated exposure to food and the social context in which food is offered.[33] Positive or negative emotions associated with the setting and type of food offered or restricted may have long-lasting effects on students' food preferences. For example, using coercive tactics such as, "If you eat your broccoli, then you can eat dessert," can be counterproductive by teaching children to dislike vegetables and making treats more attractive.

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A common practice of teachers at the elementary school level is to give students candy as a reward for good behavior.[34] Possible reward alternatives to candy include stickers or tokens that students can redeem for prizes.

Similarly, students at all levels often receive discount coupons for meals from fast food restaurants to reward academic achievements, such as reading a specified number of books during a month.[35] Students themselves can be asked to suggest captivating non-food alternatives for classrooms rewards.

Resources

- Call your state education agency to find out what nutrition education materials and professional development opportunities might be available.
- USDA's **Food and Nutrition Information Center** (FNIC) has nutrition education materials and audiovisual resources, which are available on a loan basis. Call (301) 504-5719 or go to www.nal.usda.gov/fnic. FNIC also has a database of products from the former Nutrition Education and Training Program.
- **Team Nutrition** is the implementation tool for USDA's School Meals Initiative for Healthy Children, a plan to continuously improve school meals and promote the health and education of 50 million children in 92,000 schools nationwide. Team Nutrition provides technical assistance and training to support school food service personnel. Call (703) 305-1624 or go to www.usda.gov/fns/team.htm.
- *YourSELF*, a middle school nutrition kit for teachers developed for USDA's Team Nutrition, helps students learn the power of personal choice in establishing healthy eating and physical activity patterns. To order call the **National Food Service Management Institute** (NFSMI) at (800) 321-3054.
- **Scholastic, Inc.**, in collaboration with USDA's Team Nutrition, offers an activity-based curriculum program to build skills and motivate children to make food choices for a healthy diet. Kits have been developed for pre-k–k, grades 1–2, and grades 3–5. To order, call the National Food Service Management Institute at (800) 321-3054.
- Curriculum materials for grades 3–5, developed for the Child and Adolescent Trial for Cardiovascular Health (CATCH), are available from the **National Heart, Lung, and Blood Institute** Information Center. Call (301) 251-1222 or go to www.nhlbi.nih.gov/nhlbi/cardio/other/prof/catchfly.htm.
- The **Tufts University Nutrition Navigator** from the School of Nutrition Science and Policy is an online rating and review guide designed to help those seeking nutrition information to quickly find accurate, useful nutrition information best suited to their needs. Go to http://navigator.tufts.edu/index.html.
- The **American Heart Association** has curriculum materials that address heart-healthy eating. Call (800) AHA-USA1 or go to www.americanheart.org.
- The **American Cancer Society** also has curriculum materials that address nutrition and diet. Call (800) ACS-2345 or go to www.cancer.org.

3. The Food Service Program

A policy governing the food service program needs to go beyond administrative details and clearly lay out the results expected by the policymakers. The school food service program needs to be an integral part of the overall school experience and help to reinforce students' adoption of healthy eating habits.

Healthy Eating Sample Policy, Part Three:

INTENT. The _state legislature/state board/local school board_ acknowledges that the feeding of children is primarily a family responsibility. To supplement their efforts, every school shall operate a food service program to ensure that all students have affordable access to the varied and nutritious foods they need to stay healthy and learn well.

The food service program shall aim to be financially self-supporting. However, the program is an essential educational and support activity and budget neutrality or profit generation must not take precedence over the nutritional needs of students.

PROGRAM REQUIREMENTS. During each school day the school food service program shall offer breakfast and lunch as well as snacks for students in organized after-school education or enrichment programs. Each school shall encourage all students to participate in these meal opportunities. In particular, the school shall make efforts to ensure that families are aware of need-based programs for free or reduced-price meals and that eligible families are encouraged to apply. The program shall maintain the confidentiality of students and families applying for or receiving free or reduced-priced meals.

The school food service program shall operate in accordance with the National School Lunch Act and the Child Nutrition Act of 1996 as amended and applicable laws and regulations of _state_. Schools shall offer varied and nutritious food choices that are consistent with the federal government's Dietary Guidelines for Americans. Menus should be planned with input from students, family members, and other school personnel and should take into account students' cultural norms and preferences. Food-pricing strategies shall be designed to encourage students to purchase nutritious items. Procedures shall be in place for providing to families, on request, information about the ingredients and nutritional value of the foods served.

Upon a physician's written request, modified meals shall be prepared for students with food allergies or other special food needs. Information on the ingredients used in preparation of school meals shall be provided to parents upon request. Parents shall be notified about this option.

All food service equipment and facilities must meet applicable local and state standards concerning health; safe food preparation, handling, and storage; drinking water; sanitation; and workplace safety.

Staff shall cooperate with efforts in the community to recover wholesome excess food for distribution to people in need.

EATING AS A POSITIVE EXPERIENCE. Students and staff shall have adequate space to eat meals in pleasant surroundings and shall have adequate time to eat, relax, and socialize: at least 10 minutes after sitting down for breakfast and 20 minutes after sitting down for lunch. Safe drinking water and convenient access to facilities for hand washing and oral hygiene shall be available.

STAFFING. Each *district/school* shall employ a food service director, who is properly qualified and certified according to current professional standards, to administer the school food service program and satisfy reporting requirements.

All food service personnel shall have adequate preservice training and regularly participate in professional development activities that address strategies for promoting healthy eating behavior, food safety, and other topics directly relevant to the employee's job duties.

Dining room supervisory staff shall receive appropriate training in how to maintain safe, orderly, and pleasant eating environments.

CONTRACTED SERVICES. Specified elements of the school food service program may be contracted out to food service management companies or other vendors following established open bidding procedures. The contractor(s) shall fully comply with the nutritional standards established by the U.S. Department of Agriculture (USDA) for school food programs and be subject to district auditing processes. *District/school official* shall be responsible for administering the contract. The district retains the responsibility for meeting all USDA requirements.

COORDINATION WITH OTHER PROGRAMS. The food service program shall be closely coordinated with nutrition instruction to allow students to apply critical thinking skills taught in the classroom. Food service staff shall also work closely with those responsible for other components of the school health program to achieve common goals.

A child's need for nutrients does not end when school does. Schools are encouraged to offer meals during breaks in the school calendar and to coordinate with other agencies and community groups to operate, or assist with operating, a summer food service program for children and adolescents who are eligible for federal program support.

Discussion

The U.S. Congress created the National School Lunch Program in 1946 in response to national security concerns that too many of America's youth were not healthy enough to go to war if necessary. Congress added the School Breakfast Program in 1966. Schools receive reimbursement for every meal served and additional compensation for meals served to students whose families meet federal eligibility guidelines for free or reduced-price meals. Schools also receive food supplies from the USDA commodity food program.

Today more than 93,000 public and private schools participate in the National School Lunch program,[36] although fewer than half of states *require* that school meals be offered.[37] The 26.1 million students served in fiscal year 1998 represent about half of all students enrolled in elementary and secondary schools in the United States. Nearly 54 percent of those participating were low-income children who received lunch either free or at a substantially reduced price.[38]

Schools should make every effort to ensure that families are aware of opportunities for financial assistance for school meals. Active outreach efforts might be necessary to inform some families, such as those whose primary language is not English. Note that evidence suggests that participation of low-income students is greatest when schools encourage *all* students to eat school meals and not just those who are eligible for free or reduced-price meals[39] (see box below, "School Breakfasts Energizing Minnesota Classrooms").

School Breakfasts Energizing Minnesota Classrooms

An evaluation of the effect of a universal breakfast pilot program for all students in six Minnesota elementary schools found a general increase in learning and achievement. A summary report stated:

"Clearly these pilot breakfast programs infuse a new level of energy in to the school day: students are more attentive and are in the classroom more consistently, teachers support the program and appreciate the positive effects on students, for parents the program is more consistent with the children's natural sleeping and eating routines, and it relieves some of the stress of rushed mornings. It is also an opportunity for community and parental participation in the educational process....

"By involving all students, these pilot programs eliminate the stigma of subsidized meal programs....

"According to teachers, students are more energetic at the start of the day and complaints about mid-morning hunger have noticeably decreased....

"Classes at the pilot sites lose less educational time due to discipline problems. Nutritious school breakfast increases attention span and reduces class disruption. Few students are sent to the principal's office. Administrators feel that school breakfast plays an important role in their 40 percent–50 percent decline in discipline referrals.... Nurses report a significant decline in morning visits to their offices due to minor headaches and stomachaches. They conclude school breakfast is the reason students are spending less time at their office and more time in the classroom."

—Minnesota Department of Children, Families, and Learning[39]

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School food service is an essential aspect of the educational mission of schools. Yet four-fifths of middle and high school food service coordinators have reported that their food service programs were expected to break even financially, not including salaries.[37] Furthermore, more than one-fourth said that their programs were expected to earn money *beyond* the costs of the program.[37] Education decision makers should not let financial pressures blind them to the larger purpose of food service programs, which is to promote academic achievement and good health.

The importance of breakfast

Research findings on the importance of a nutritious breakfast are compelling. A widely cited study in Lawrence, Massachusetts found that students who participated in the school breakfast program achieved higher scores on the Comprehensive Tests of Basic Skills and decreased their rates of absence and tardiness.[13] Another study in Philadelphia and Baltimore found that students who increased their participation in the school breakfast program had greater increases in their math grades and decreases in their rates of absence and tardiness than children whose participation remained the same or decreased[14] (see box, "Research Shows School Breakfast Program May Improve Children's Behavior and Performance").

Despite these compelling findings, only 74 percent of schools that participate in the School Lunch Program also participate in the School Breakfast Program.[40] Many fewer schools participate in the Summer Food Service Program for Children. As a result, only 42 percent of the children who receive free or reduced-price lunches also eat school breakfast,[40] and only 15 percent receive meals when school is closed for the summer.[41]

School breakfast programs do not benefit only low-income children. The 1992 School Nutrition Dietary Assessment Study conducted by the USDA found that 12 percent of students ate no breakfast at all.[42] All schools should do everything possible to fit breakfast into their morning schedules.

Research Shows School Breakfast Program May Improve Children's Behavior and Performance

Four months after the schools started a free breakfast program in one Philadelphia and two Baltimore public schools, the number of students eating breakfast had nearly doubled, and reports on the students indicated they were significantly more attentive in the classroom, earned higher grades in math, and had significantly fewer behavioral and emotional problems.

The Harvard study followed 133 students before and after the start of a universally free School Breakfast Program. Before the program, only about one-third of the children ever ate breakfast at the school. After the program started, nearly two-thirds of the students ate breakfast at the school sometimes or often. Students who increased their school breakfast participation showed significantly larger gains in math grades, decreased rates of tardiness, absences, and hyperactivity as well as decreased depression and anxiety than students whose school breakfast participation did not increase.

—Murphy et al.[14]

The Dietary Guidelines for Americans

- **Eat a variety of foods.**
- **Balance the food you eat with physical activity—maintain or improve your weight.**
- **Choose a diet with plenty of grain products, vegetables, and fruits.**
- **Choose a diet low in fat, saturated fat, and cholesterol.**
- **Choose a diet moderate in sugars.**
- **Choose a diet moderate in salt and sodium.**
- **If you drink alcoholic beverages, do so in moderation [not applicable to children and adolescents].**

—U.S. Department of Agriculture
and U.S. Department of Health
and Human Services[1]

Planning meals

Food selection and menu preparation for federally funded school meals was largely at the discretion of local food service personnel until 1994, when Congress directed that school meals comply with the scientifically-determined Dietary Guidelines for Americans (DGAs).[1]

Public health officials stress the importance of modifying children's consumption of total fat and saturated fat. As an example of what can be done to conform to the dietary guidelines, switching from two-percent fat to one-percent fat milk cuts the saturated fat in school meals but maintains the level of nutrients. A large number of resources are available to help food service programs improve menu planning: see the list of resources at the end of this section.

The USDA is also urging schools to offer students choices among a variety of nutritious food options instead of serving the same thing to everyone. It is important to involve students in meal planning so that nutritious meals appeal to them. Schools should aim for maximum student participation in the school food program.

Confidentiality

Being eligible for free or reduced-price school meals can be stigmatizing to a young person. The desire to avoid shame can cause students to forgo participating in the school food service program. It is therefore very important that the procedures for applying and for entering dining areas be designed in ways that preserve the privacy of students and their families (see box, "Tips for Preventing Overt Identification," on the following page).

Schools Adding Meal Variety

- **[In Hanover, Pennsylvania] South Western High's daily pasta bar, which offers a different noodles-and-sauce dish each day, is a hit.**
- **Oregon schools have installed "variety bars," featuring eight to 10 fresh fruits and vegetables that students choose themselves.**
- **T.C. Williams High School in Alexandria, Virginia, created three in-cafeteria "restaurants" serving Italian, Spanish, and Asian food daily.**
- **Cooks at Mount Diablo schools in Concord, California make pizza from scratch with whole-wheat crusts and less cheese and serve juice for dessert.**

—USA Today[43]

Nevertheless, schools may disclose, without consent, the names of students who are eligible for free milk or free or reduced-price meals to officials directly connected with the administration or enforcement of certain programs specified in the federal Healthy Meals for Healthy Americans Act of 1994, such as Medicaid. Any disclosure of confidential information must be in strict compliance with the regulations and guidance issued by USDA.

Personnel qualifications

The recent statutory mandate that school meals meet the standards of the Dietary Guidelines for Americans makes it critical that school food service personnel have the necessary training, equipment, and management support to carry out their responsibilities. However, there are troubling indications that this may be not the case in many places. For example, a 1994 national study found that only 65 percent of school districts maintained written job descriptions for school food service staff, and only 45 percent had developed written staff performance standards.[37]

These administrative weaknesses were not just at the district level. The study found that only 11 states offered certification for food-service directors; only five states required it for employment at the district level; and only three states required certification for school-level food service directors.[37]

States that do not offer certification ought to consider establishing it. A basic understanding of the growth and development of children and adolescents is necessary for school food service personnel. Key employees also need education and skills development sessions in a variety of topics including:

- personnel management;
- financial management and record keeping;

Tips for Preventing Overt Identification

The National School Lunch Act requires schools to take whatever measures are necessary to ensure that there is no overt identification of any child eligible for free or reduced-price meals by special tokens, announced or published lists of names, or by other means.

Generally, a school which has made tickets or tokens readily available to all students (i.e., free, reduced and full price) at the same time and place and has done a reasonable job of announcing ticket/token availability would have protected free and reduced price students from overt identification. If, however, such tickets or tokens are coded or colored in a manner which would overtly identify free and reduced price recipients, the resultant overt identification would be unacceptable.

A "reasonable" job of announcing ticket availability means that advertisements or announcements are made on a regular basis to the whole student body, and none but the appropriate school officials know the extent of full price ticket sales. If the ticket/token system is not widely used by full price students, it is strongly recommended that schools consider such options as (1) offering a discount price on ticket purchases, (2) working with the local parent teacher organization to increase sales; or (3) utilizing a different collection procedure.

—U.S. Department of Agriculture[44]

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- cost- and labor-efficient food purchasing and preparation;
- sanitation and safe food handling, preparation, and storage;
- planning menus for students with special needs and students of diverse cultural backgrounds;
- customer service and student and family involvement;
- marketing healthy meals; and
- principles of nutrition education.

Multi-lingual training might be needed for some to achieve the necessary level of preparation.

Contracted services

Some districts and schools contract out their school meal services in an effort to save money and simplify administration: in 1994, 17 percent of middle and high schools contracted with fast-food restaurants to offer foods for school meals.[37] Some private food service contractors may have secondary motives of influencing attitudes, building long-term "brand loyalty," or test marketing new food products.

School and district officials who are responsible for administering bidding and contract management processes need to ensure that:

- nutritious foods are consistently served;
- USDA regulations are scrupulously followed;
- the educational goal of fostering healthy eating patterns is not undermined by advertising or other commercial efforts to influence students' food choices; and
- rigorous local auditing and oversight requirements are established and enforced.

School dining areas

The context that surrounds a person exerts a powerful influence on behavior. A pleasant dining area encourages students to pay attention to what they are eating and enjoy the sensory and social aspects of a healthy meal.

A safe and pleasant dining area is one in which:

- tables and chairs are of the appropriate sizes for students;
- seating is not overcrowded;
- students have a relaxed environment for socializing (round tables are said to encourage a sense of family);
- noise is not allowed to become excessive;
- rules for safe behavior are consistently enforced;
- tables and floors are cleaned between lunch periods;
- the physical structure is in good repair; and
- smells are not offensive.

Schools can invite ideas from students about how to decorate the dining room area to make it attractive to young people of their age group.

Food recovery, or gleaning

USDA policy allows schools that participate in its child nutrition programs to donate leftover food to public interest groups, such as charitable organizations, for the purpose of feeding needy persons. Out of concern about the wholesomeness of the food and the use of proper food safety procedures, USDA recommends that schools involve their local health official before they donate food. A federal "Good Samaritan" law can help ameliorate liability concerns.

Food Service Staff as Educators

School food service personnel can reinforce nutrition education by:

- visiting classrooms and explaining how students can make sure meals meet the standards of the Dietary Guidelines for Americans;[1]
- inviting classes to visit the cafeteria kitchen and teaching students how to prepare healthy foods;
- involving students in planning the school menu and preparing recipes;
- offering foods that reinforce classroom lessons (e.g., serving whole wheat rolls to reinforce a lesson on dietary fiber);
- posting fliers and posters on nutrition in the cafeteria; and
- displaying nutrition information about available foods and giving students opportunities to practice food analysis and selection skills learned in the classroom.

—Centers for Disease Control and Prevention[19]

Integration with other school activities

Food service staff can work with nutrition education teachers in a number of ways to educate students about the school meals program and the importance of making healthy eating choices (see box, "Food Service Staff as Educators"). They can also disseminate this information by collaborating with school administrators, physical education teachers, coaches, nurses, counselors, leaders of the parents' association, and other key members of the school community.

To help the school community see that food service is an integral part of the educational program, food service staff should be as actively involved as other school staff in school management activities, such as participation in the school health council. A 1994 national survey found that food service staff served on school health councils in only eight percent of the schools that had such councils.[45]

Resources

- USDA's *Healthy School Meals, Healthy Kids: A Leadership Guide for School Decision Makers* shows, step-by-step, how school decision makers can use materials and resources developed by USDA and its partners. The guide is available free to school administrators, school districts, and state agencies by contacting USDA's **Food and Nutrition Information Center** at (301) 504-5719 or writing to USDA's Team Nutrition, 3101 Park Center Drive, Room 1010, Alexandria, VA 22302.

- *The School Breakfast Scorecard* produced annually by the **Food Research and Action Center** (FRAC) summarizes current research on the importance of school breakfast, highlights proven strategies to overcome barriers to the establishment of school breakfast programs, and provides state-by-state data on program implementation. Call (202) 986-2200 or go to www.frac.org.

- The **U.S. Department of Agriculture** regulations governing the National School Lunch and National School Breakfast programs can be found online at http://schoolmeals.nal.usda.gov:8001/Regulations/regs.html.

- USDA's **Team Nutrition** provides technical assistance and training to support school food service personnel. Call (703) 305-1624 or go to www.fns.usda.gov/tn.

- Information about the training component of Team Nutrition is available from the **Healthy School Meals Resource System** at www.nal.usda.gov:8001. Among the many materials available online is the entire text of *Serving It Safe: A Manager's Tool Kit* and *A Menu Planner for Healthy School Meals*.

- The **National Food Service Management Institute** at the University of Mississippi is a national resource center designed to support administrators and providers of child food and nutrition programs. The institute's activities include conducting applied research, developing education and training materials, and providing technical assistance to school food service professionals. Call (800) 321-3054 or go to www.olemiss.edu/depts/nfsmi.

- The **American School Food Service Association** provides a variety of education opportunities for school food service professionals, notably the Healthy Edge training program. They can also provide assistance with information campaigns for the public, teachers, parents, and students and practical guidance on contracting with private food service management firms. Call (703) 739-3900 or visit www.asfsa.org.

- *The Travel Guide to Healthy School Meals* (1998) from the Child Nutrition Programs office of the **Oregon Department of Education** is a step-by-step training program for food service workers. Call (503) 378-3579 or download the entire 120-page guide at www.ode.state.or.us/stusvc/nutrition/resources/trvlguid.pdf.

- The Food and Nutrition Services home page of the **Wisconsin Department of Public Instruction** includes an extensive Administrative and Financial Management Handbook for school food service programs that contains practical guidance on challenging issues. Go to www.dpi.state.wi.us/dpi/dfm/fns.

- **Mealtalk** is an interactive electronic discussion group (listserv) that links professionals who are operating child nutrition programs so that they can share resources, information, and innovative solutions to common day-to-day problems. Subscribe through the Healthy School Meals Resource System at http://schoolmeals.nal.usda.gov:8001.

- Information on the federal **Summer Food Service Program** can be found at www.usda.gov/fns/cnp/sfsp.htm.

- Information on surplus food recovery programs can be found at www.usda.gov/fns/glean.htm.

- The *Eat Smart School Nutrition Program Guide* from the **National Heart, Lung, and Blood Institute** gives school food service personnel tools to reduce the fat, saturated fat, and sodium in school meals. The guide provides materials for training personnel, planning menus, and purchasing heart-healthy commodity and vendor products. It also offers tips on how to promote the program to children and new kid-tested recipes. For more information call (301) 592-8573 or go to www.nhlbi.nih.gov.

- The **Partnership for Food Safety Education**, composed of industry, state, and consumer organizations and numerous federal agencies, is conducting a broad-based public education campaign called "Fight BAC!" For information and educational materials go to www.fightbac.org.

- The Center for Food Safety and Applied Nutrition of the **U.S. Food and Drug Administration** operates a gateway website that provides links to selected government information on food safety. Go to www.FoodSafety.gov.

4. Other Food Choices at School

Students' eating habits are greatly influenced by the types of food and drink that are available to them. Policies that are intended to promote healthy eating need to address all food and beverages sold or served to students, including those available outside of the school meals program.

Healthy Eating Sample Policy, Part Four:

NUTRITIOUS FOOD CHOICES. Nutritious and appealing foods, such as fruits, vegetables, low-fat dairy foods, and low-fat grain products, shall be available wherever and whenever food is sold or otherwise offered at school. Schools shall take efforts to encourage students to make nutritious food choices.

Food and beverages sold or served on school grounds or at school-sponsored events shall meet nutritional standards and other guidelines set by the *state/district/school health council/nutrition committee*. This includes:

- à la carte offerings in the food service program;
- food and beverage choices in vending machines, snack bars, school stores, and concession stands;
- food and beverages sold as part of school-sponsored fundraising activities; and
- refreshments served at parties, celebrations, and meetings.

FOOD SALES. The sale of all foods on school grounds shall be under the management of the school food service program, except foods sold as part of a fundraising activity. In middle and high schools, food and beverages shall not be sold from vending machines or school stores *during school hours/until 30 minutes after the end of the last lunch period* unless they are part of the school food service program. Profits generated from sales of foods or beverages in vending machines or school stores will accrue to the *food service program/student organizations approved by whom.*

Only student organizations and legally constituted, nonsectarian, nonpartisan organizations approved by *whom* are permitted to engage in fundraising on school grounds at any time. These organizations are encouraged to raise funds through the sale of items other than food. Foods sold for fundraising purposes shall not be sold while school food service meals are being served. Each organization raising funds by selling foods is limited to one event per month during school hours.

Elementary school students shall not have access to food or beverages sold in vending machines or school stores.

CLOSED CAMPUS. Students are not permitted to leave school grounds during the school day to purchase food or beverages.

COMMERCIAL ADVERTISING. Partnerships between schools and businesses are encouraged, and business sponsorship of educational activities and materials shall be duly acknowledged. However, such partnerships shall be designed to meet identified educational needs, not commercial motives, and shall be evaluated for educational effectiveness by the school/district on an ongoing basis.

Discussion

School policies can help shape social norms that influence the dietary habits of students and staff. A policy to promote nutritious food choices at school should make sure that, at every possible eating occasion, students have opportunities to practice what they are taught in nutrition education and choose nutritious snacks that are nutrient-dense and low in fat, sodium, and added sugars. A sound policy ensures that:

- nutritious foods are always available as an affordable option whenever food is served or sold;
- students have limited opportunities to eat snacks high in fat, sodium, or added sugars; and
- competition with nutritious meals served by the school food service program is minimized.

A policy to promote nutritious food choices needs to address *all* food and beverages sold and/or served to students that compete with USDA-reimbursable meals and after-school snacks, including:

- à la carte items (separate food choices) offered by the food service program;
- foods and beverages sold from vending machines, snack bars, and school stores;
- candy bars, cakes, and other food items sold for fundraising purposes; and
- refreshments that are available at school parties, celebrations, and meetings.

Limited choices in many schools

Students have little opportunity to make prudent dietary choices in too many schools. Some evidence:

- The most common types of food offered in school vending machines are soft drinks, chips, desserts, and candy.[42]
- A 1994 study of vending machines in 55 Minnesota high schools found that 54 percent of the schools with vending machines sold chips, but only 27 percent sold pretzels; 56 percent sold candy, but only eight percent sold fruit.[46]
- Fruit and yogurt were offered in vending machines in less than one percent of the nation's schools in 1992.[42]

- Studies have found that, even in school cafeteria à la carte lines, the most common snacks and beverages offered are desserts, juices, juice drinks, ice cream, and chips.[42]

As Parcel and colleagues have written, "...a child cannot practice what he has learned [in the classroom] if offered only high-fat, high-sodium foods...."[47] Presenting students with these kinds of limited food options sends a powerful message about what is considered acceptable dietary behavior by school leaders.

According to the American Dietetic Association, the availability of "competitive foods" is especially problematic because it can:

- decrease students' intake of nutritious foods offered for school meals;
- place school food service programs in financial jeopardy because of low student participation rates; and
- lead to the perception that school meals are only for needy children, thereby stigmatizing participants.

Federal standards

Although the federal government has established standards that require schools to provide meals consistent with the Dietary Guidelines for Americans, these standards do not apply to foods sold outside the school meals programs.[48,49] The only federal regulations that address competitive foods prohibit the sale of "foods of minimal nutritional value" in food service areas during meal times.[50] Foods of minimal nutritional value are those that provide less than five percent of the U.S. recommended daily allowance per serving for protein, vitamin A, vitamin C, niacin, riboflavin, thiamin, calcium, and iron. These "foods" are classified into four categories: carbonated soft drinks, chewing gum, water ices, and certain candies made predominantly from sweeteners, such as hard candy, licorice, jelly beans, and gum drops.

Competitive Foods Are Widely Available

National data on the extent to which competitive foods are offered in schools are available from the USDA's 1992 School Nutrition Dietary Assessment Study[42] and from CDC's 1994 School Health Policies and Programs Study.[37] These studies found that:

- 78 percent of high schools, 65 percent of middle schools, and 31 percent of elementary schools offered foods à la carte;[42]
- 88 percent of high schools,[43] 61 percent of middle schools,[43] and 14 percent of elementary schools[42] had food or beverage vending machines that students were allowed to use;
- 34 percent of high schools and 15 percent of middle schools permitted students to use school vending machines at any time,[43] and six percent of elementary schools allowed students to use vending machines during lunch;[42]
- 15 percent of high schools, 10 percent of middle schools, and two percent of elementary schools sold food through a school store or snack bar;[42] and
- 42 percent of high schools and 25 percent of middle schools allowed foods to be sold for fundraising purposes during school meal periods.[37]

The regulations permit foods of minimal nutritional value to be sold in the cafeteria before and after school meal periods and outside of the cafeteria at any time. Further, the regulations do not restrict the sale of other common snack foods including chips, most candy bars, and noncarbonated, high-sugar beverages that are not 100 percent juice, such as "sports drinks."

Model standards

In the absence of strong federal regulations, a number of states and districts have established more comprehensive policies. These policies can serve as models for the councils or committees that are charged with establishing nutritional standards for school food choices and with determining when students can have access to foods sold in vending machines or school stores.

West Virginia has established probably the most detailed state regulations on competitive foods by issuing clear standards to identify the types of foods that cannot be sold or offered on school campuses (see box, "Foods Prohibited for Sale at School").

California has developed a nutritious foods list and requires that half of all food items offered for sale by any organization or entity at any location on the school premises must come from the list (reimbursable food items from the federal school meals programs are not included in the calculation).[52] The list of nutritious foods includes dairy products, juices (at least 50 percent full strength), fruits, vegetables, nuts, grain products, meats, legumes, and any foods that would qualify as one of the required food components of the school lunch meal pattern.

California also sets limits on the number of times student organizations can sell food items on campus and on the number of different types of food items they can sell.[53] Organizations that are planning fundraising drives can be encouraged to consider a variety of alternative items that can be sold instead of foods or beverages, such as gift wrap, flowers, greeting cards, or clothing with the school logo.

CDC's "Guidelines for School Health Programs to Promote Lifelong Healthy Eating"[19] includes a list of foods low in saturated fat that can be stocked in vending machines (see box, "Vending Machine Foods Low in Saturated Fat," on the following page).

Foods Prohibited for Sale at School

The West Virginia Board of Education prohibits the sale or serving of the following foods at school:

- **chewing gum, flavored ice bars, and candy bars;**
- **food or drinks containing 40 percent or more, by weight, of sugar or other sweeteners;**
- **juice or juice products containing less than 20 percent real fruit or vegetable juice; and**
- **foods with more than eight grams of fat per one ounce serving.**

In addition, soft drinks are prohibited at elementary and middle schools.[51]

The state department of education provides schools with colorful booklets that contain creative ideas for foods that can be served at school parties that meet the state's strict standards for competitive foods (see the resources list).

Vending machine placement and hours of operation

Elementary school students should not have access to foods sold in vending machines and school stores because young children lack the maturity to make healthy and safe food choices. For example, children who have food allergies might not have the awareness or the ability to avoid foods that could spark a dangerous reaction.

At the middle/junior high school and high school levels, many schools and districts have decided to keep all vending machines turned off during regular school hours. Others keep the machines off until the end of the last lunch period. A number of states prohibit the sale of "foods of minimal nutritional value" on school campuses until 30 minutes after the last lunch period. Some states and districts prohibit the sale of carbonated soft drinks until the end of the school day.

Placing vending machines in convenient locations can encourage their use; conversely, placing them in out-of-the-way places can discourage their frequent use. Placement near dining areas can detract from students' participation in the school food service program.

School food service directors should be made responsible for managing the sale of competitive foods for two reasons:

1) to minimize negative effects of this competition on the food service program; and

2) most importantly, to make sure that all decisions related to foods sold at school are based first and foremost on the nutritional needs of young people.

Vending Machine Foods
Low in Saturated Fat

- Canned fruit
- Fresh fruit (e.g., apples and oranges)*
- Fresh vegetables (e.g., carrots)
- Fruit juice and vegetable juice
- Low-fat crackers and cookies, such as fig bars and gingersnaps
- Pretzels
- Bread products (e.g., bread sticks, rolls, bagels, and pita bread)
- Ready-to-eat, low-sugar cereals
- Granola bars made with unsaturated fat
- Low-fat (one percent) or skim milk*
- Low-fat or nonfat yogurt*
- Snack mixes of cereal and dried fruit with a small amount of nuts and seeds†
- Raisins and other dried fruit†
- Peanut butter and low-fat crackers§

* These foods are appropriate if the vending machine is refrigerated.

† Some schools might not want to offer these items because these foods can contribute to dental caries.

§ Some schools might not want to offer peanut butter; although it is low in saturated fatty acids, peanut butter is high in total fat.

—Centers for Disease Control and Prevention[19]

Beverage and food vending sales contracts

Many schools depend heavily on profits from vending machine sales of carbonated beverages and snack foods such as chips, candy, and cookies. Exclusive "pouring rights" beverage marketing contracts with bottling companies are increasingly common. These lucrative contracts typically include incentives that link revenue for schools to the volume of beverages sold and, thereby, give educators a strong incentive to encourage students to buy soft drinks.

In recent years, consumption of milk by children and adolescents has decreased substantially and their consumption of soft drinks has increased dramatically (see box, "Soft Drink Consumption Soars and Milk Consumption Falls," below). Some nutritionists are concerned that soft drinks are replacing milk and juice in children's

Soft Drink Consumption Soars and Milk Consumption Falls

- Between 1977–78 and 1994–96, fluid milk consumption dropped by 24 percent among boys and by 32 percent among girls 6–11 years old, and by one-third among both males and females 12–19 years old. In the same period, the proportion of individuals of all ages who drank carbonated soft drinks increased by 52 percent.[54]
- Between 1989–91 and 1994–95, among children ages 12–17, mean consumption of milk and milk products declined by 6.2 percent, and mean consumption of soft drinks increased by 41 percent. USDA Economic Research Service data showed that, during this time period, per capita consumption of soft drinks increased from 45.4 to 52.2 gallons per year.[59]
- A 1998 USDA study of the food acquisitions of public unified school districts concluded that "there has been a virtual revolution in beverage use" within school food programs. Between the 1984–85 and the 1996–97 school years, the volume of milk acquired decreased by 29 percent, the volume of fruit drinks (not 100 percent fruit juice) acquired increased by 181 percent, and the volume of carbonated sodas acquired increased by 1,103 percent. In 1984–85, fruit drinks and carbonated sodas composed only 2.6 percent of the total volume of beverages acquired; in 1996–97, they composed 11.0 percent of the total volume of beverages acquired.[55]
- In 1994, 57 percent of adolescent boys and 52 percent of adolescent girls drank fluid milk on any given day, whereas 74 percent of adolescent boys and 65 percent of adolescent girls drank carbonated soft drinks on any given day.[54]
- An analysis of data from a national survey of children and adolescents found that energy intake was positively associated with consumption of nondiet soft drinks and that those in the highest soft drink consumption category consumed less milk and fruit juice than those who did not consume soft drinks.[60]
- Adolescents ages 12–17 get, on average, 11 percent of all their calories from carbonated beverages, fruit-flavored and part-juice drinks, and sports drinks; they consume, on average, 15 teaspoons of sugar per day from these drinks, or 48 percent of their total intake of refined sugar.[3]
- Milk and juice are among the top sources of vitamin A, vitamin C, B vitamins, calcium, magnesium, and phosphorus for children in the United States.[56,57] The typical 12-ounce container of a nondiet carbonated soda provides approximately 150 calories, nine teaspoons of sugar, and no minerals or vitamins.[59]
- Caffeine, a mildly addictive stimulant drug, is present in most cola drinks as well as in some orange sodas and other products. Caffeine can cause nervousness, irritability, sleeplessness, and rapid heart beat. Boys in the 90th percentile of soft-drink consumption consume as much caffeine as in two cups of coffee; for girls, the amount is one and one-half cups of coffee.[58]

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diets, which can lead to a negative effect on nutrition.[59,60]

School policymakers need to critically examine the details, and anticipate the consequences, of beverage and food vending sales contracts. Contracts should never include incentives for increasing students' consumption of foods or drinks that have little nutritional value. Moreover, contract provisions can help guide sales in more positive directions if they specify that:

- 100 percent fruit juice or bottled water must compose a certain proportion of the beverage products offered for sale (e.g., 50 percent in California);
- 100 percent fruit juice and bottled water are sold at attractive prices;
- soft drink container sizes are moderate, because the larger the container the more beverage people are likely to drink;[58] and
- the vendor helps sponsor promotional materials and events to encourage healthy eating.

Studies have found that students' selection of low-fat items in vending machines and on à la carte lines increases substantially when the prices of those items are reduced, even without any nutrition education efforts.[61,62] It is possible that these price reductions could be paid for by subsequent increases in total sales volume or by concurrent increases in the prices of less nutritious snack items.

Schools also should make sure that students and staff have convenient access to good drinking water as an alternative to soft drinks.

Promoting nutritious choices

Making nutritious choices available is a critical step, but it is only a first step. At the same time, schools should work with nutrition educators and vendors to design and implement educational and marketing activities on an ongoing basis to increase students' demands for snacks low in fat, sodium, and added sugars. This could include:

- placing promotional signs, labels, and posters in the dining area and throughout the school building;
- sponsoring contests and other fun promotional activities;
- engaging student groups to develop their own campaigns to promote nutritious snack choices at school; and
- manipulating the prices of snacks sold at school.

School staff should be advised that serving nothing but sugar-laden cupcakes and soft drinks at classroom parties could send an unintended message that important adults consider such foods to be highly desirable. People who bring food to parties and other celebratory events at school should be encouraged to bring healthy choices in addition to— or instead of— treats laden with fat and sugar.

Advertising on school grounds

Business involvement in schools is widely considered beneficial and desirable because of the ties built between the school and the community. Some see advertising and other promotional activities as an inevitable and necessary aspect of valuable public–private partnerships. Schools can receive positive local press for their efforts to supplement meager budgets by allowing commercial promotion on campus.

However, public schools are taxpayer-funded, and so selling or providing free access to advertising at school involves ethical and legal issues that must be addressed.

Critics of commercialism in schools argue that private companies sometimes do not have the best interests of students in mind. They assert that schools are charged with protecting the welfare of students and should not allow students to be used as a captive audience for private gain. Furthermore, some critics note that it is not even particularly profitable for schools to engage in such partnerships; the relatively small sums of money that corporate sponsors pay in exchange for permission to advertise simply is not worth the risk of damaging the public's trust in the public education system.

> **An Obligation to Protect Students**
>
> **School-business relationships based on sound principles can contribute to high-quality education. However, compulsory attendance confers on educators an obligation to protect the welfare of their students and the integrity of the learning environment.... Selling or providing access to a captive audience in the classroom for commercial purposes is exploitation and a violation of the public trust.**
>
> —National Association of State Boards of Education[63]

It can be difficult to define the line where appropriate corporate support, with visible acknowledgment of it, becomes inappropriate intrusion into the educational mission of schools. For example, should fast-food companies be allowed to distribute coupons to reward academic performance? Consider that another way to frame the same question is, should the valid educational goal of motivating students to excel override the equally valid goal of promoting healthy eating?

Following are some principles suggested by the 1998 NASBE Resolutions Committee to help guide state boards of education:

- Corporate involvement should always support the goals and objectives of the schools.
- School-business partnerships have to be structured to meet identified education needs, not commercial motives, and need to be evaluated for educational effectiveness by the school/district on an ongoing basis.
- Schools should not require students to observe, listen to, or read commercial advertising.
- Curriculum and instruction have to remain within the purview of educators. Schools and educators ought to hold sponsored and donated materials to the same standards used for the selection and purchase of curriculum materials. School-business agreements should not influence the decisions of school leaders and teachers about the use of sponsored materials.

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Closed campuses

A closed-campus policy can help discourage students from obtaining fast foods and snacks (or smoking cigarettes or joyriding). In 1992, 38 percent of high schools, 23 percent of middle schools, and 20 percent of elementary schools permitted students to leave school during lunch hours.[42] Only one state mandates that every school enforce a closed-campus policy during lunch hours.[37]

A closed-campus policy might not be feasible everywhere. Some factors to consider are the capacity of the school food service program, the availability of on-campus dining facilities, and the practical ability of the school to enforce a closed-campus policy.

Moving from an open- to a closed-campus policy might take time and effort. Students can be enlisted to help draw up a systematic plan to move in that direction. A good first step could be to collect information about the effects of the current policy to build a solid rationale for a policy change that is likely to be unpopular with many students and local merchants. Some questions to investigate include:

- What do students eat and drink off campus?
- What do the police report about students' behavior away from school?
- What do parents think about allowing their children to go off campus without adult supervision?
- Are there problems with student tardiness or attendance after lunch?
- Does the open-campus policy encourage students to drive to school? What is the effect on the parking situation?
- What is the financial burden on students who succumb to pressure to join their friends off campus?

Resources

- **The American School Food Service Association** (ASFSA) has adopted a statement on competitive foods. Call (703) 739-3900.

- **The American Dietetic Association** (ADA) has a position paper on competitive foods in schools. To obtain a copy call (800) 877-1600 or see the *Journal of the American Dietetic Association*, 1991; 91: 1123–1125.

- The **West Virginia Department of Education**'s Office of Child Nutrition has produced *Let's Celebrate: A World of Healthy Foods*, with nutritious recipes and party ideas drawn from many different cultures, and *Let's Party: Party Ideas for School and Home* to provide practical guidance on serving nutritious food items. Call (304) 558-2708.

- The **Center for Science in the Public Interest** (CSPI), a nonprofit education and advocacy organization, offers *Liquid Candy: How Soft Drinks are Harming Americans' Health* and other information for the public about common dietary habits. Call (202) 332-9110 or go to www.cspinet.org.

- The **Center for Analysis of Commercialism in Education** (CACE) at the University of Wisconsin-Milwaukee has produced a paper entitled *Integrating the Schoolhouse and the Marketplace.* Call (414) 229-2716 or visit www.uwm.edu/Dept/CACE.

- The **Center for Commercial-Free Education** is a national non-profit advocacy organization that addresses the issue of commercialism in public schools. Call (510) 268-1100 or go to www.commercialfree.org.

5. Services for Nutrition-Related Health Problems

School personnel can play a positive role in recognizing nutrition-related health problems among students, their families, and school staff, and then help them to access feeding programs, other community services, and/or appropriate medical treatment. Consequently, schools should provide nutrition services as an integral component of school health services.

Healthy Eating Sample Policy, Part Five:

NUTRITION-RELATED HEALTH PROBLEMS. School counselors and school health services staff shall consistently promote healthy eating to students and other staff. These professionals shall be prepared to recognize conditions such as obesity, eating disorders, and other nutrition-related health problems among students and staff and be able to refer them to appropriate services.

Discussion

Some students and staff might have psychologically based eating disorders and need immediate professional treatment. Specific disorders include bulimia nervosa (frequent episodes of binge eating followed by purging and intense feelings of guilt or shame), anorexia nervosa (preoccupation with dieting and thinness that leads to excessive weight loss), and compulsive eating (uncontrolled binge eating). Other potential nutrition-related problems that merit attention relate to physical disabilities, poor oral health, and pregnancy.

School personnel can help. According to the American Academy of Child and Adolescent Psychiatry:

> With comprehensive treatment, most teenagers can be relieved of the symptoms or helped to control eating disorders. Treatment for eating disorders usually requires a team approach including individual therapy, family therapy, working with a primary care physician, working with a nutritionist, and medication. Many adolescents also suffer from other problems including depression, anxiety, and substance abuse. It is important to recognize and get appropriate treatment for these problems as well. Research shows that early identification and treatment leads to more favorable outcomes.[64]

Schools can also play a role in treating, as well as preventing, obesity. A number of school-based treatment studies with overweight adolescents have shown positive, albeit modest, short-term results.[65] Few of these studies have been conducted in recent years, however, perhaps because of a fear that school-based obesity treatment programs can stigmatize participants.[65]

To help prevent other serious health problems, coaches, athletic aides, and other school staff should actively discourage students' use of dietary supplements to enhance athletic performance or personal appearance (see pages D-42–43 in the chapter entitled, "Policies to Encourage Physical Activity," for information about the limited benefits and possible dangers of dietary supplements). Possession of these substances on school grounds should be treated like medications that require written parental approval.

Staff training

School health care providers, counselors, psychologists, and social workers should participate in training activities that address eating disorders, obesity, and other nutrition-related problems. These professionals could be asked in turn to brief other school staff about danger signs and symptoms to watch for.

In addition, first aid courses for *all* school staff should include training in emergency response for choking and allergic reactions.

Services for Nutrition Problems

Essential nutrition services include screening for and identification of nutrition problems, nutrition counseling, and referral. The primary provider of school-based nutrition services should be a qualified nutrition professional. However, other school health service providers may be responsible for screening students for nutrition problems, making referrals to qualified nutrition professionals, and providing support and reinforcement for nutrition care provided....

If schools cannot provide these services, they should arrange for and monitor their provision from qualified nutrition professionals in the community.

—Position of the American Dietetic Association, the Society for Nutrition Education, and the American School Food Service Association[64]

Resources

- *School-Based Nutrition Programs and Services* is a joint position paper of the **American Dietetic Association** (ADA), the **Society for Nutrition Education** (SNE), and the **American School Food Service Association** (ASFSA). ADA has an additional position paper on child nutrition services. Call (800) 877-1600, or go to www.eatright.org/school-based.html.
- USDA's Food and Nutrition Information Center offers a list of *Professional Resources about Eating Disorders*, including contact information for a variety of organizations. Call (301) 504-5719 or go to www.nal.usda.gov/fnic.

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References

[1] U.S. Department of Agriculture and U.S. Department of Health and Human Services, "Nutrition and your health: Dietary Guidelines for Americans," 4th edition, 1995.

[2] Dwyer, J., "The School Nutrition Dietary Assessment Study," *American Journal of Clinical Nutrition*, 1995; 61(1 suppl): 173S–177S.

[3] Centers for Disease Control and Prevention, unpublished analysis of the U.S. Department of Agriculture, *Continuing Survey of Food Intake by Individuals (1 Day), 1994–96.*

[4] U.S. Department of Health and Human Services, "Healthy People 2010 Objectives: Draft for public comment," 1999.

[5] Food and Nutrition Service, "Household food security in the United States, 1995–1998 (Advance report)," U.S. Department of Agriculture, July 1999. Available at www.fns.usda.gov/oane.

[6] Alaimo, K. et al., "Food insufficiency exists in the United States: Results from the Third National Health and Nutrition Examination Survey (NHANES III)," *American Journal of Public Health*, 1998; 88(3): 419–426.

[7] Nutrition-Cognition National Advisory Committee, "Statement on the link between nutrition and cognitive development in children," Center on Hunger, Poverty, and Nutrition Policy, Tufts University School of Nutrition, July 1996. Available at www.penpages.psu.edu.

[8] Pollitt, E. et al., "Brief fasting, stress, and cognition in children," *American Journal of Clinical Nutrition*, 1981; 34: 1526–1533.

[9] Pollitt, E. et al., "Fasting and cognitive function," *Journal of Psychiatric Research*, 1982–83; 17(2): 169–174.

[10] Kleinman, R.E. et al., "Hunger in children in the United States: Potential behavioral and emotional correlates," *Pediatrics*, 1998; 101(1): E3.

[11] Murphy, J. et al., "Relationship between hunger and psychosocial functioning in low-income American children," *Journal of the American Academy of Child and Adolescent Psychiatry*, 1998; 37(2): 163–170.

[12] Amschler, D., "Calcium intake in adolescents: An issue revisited," *Journal of School Health*, 1999; 69(3): 120–122.

[13] Meyers, A. et al., "School Breakfast Program and school performance," *American Journal of Diseases of Children*, 1989; 143: 1234–1239.

[14] Murphy, J. et al., "The relationship of school breakfast to psychosocial and academic functioning," *Archives of Pediatric and Adolescent Medicine*, 1998; 152: 899–907.

[15] McGinnis, J.M. and Foege, W.H. "Actual causes of death in the United States," *Journal of the American Medical Association*, 1993; 270(18): 2207–2212.

[16] National Research Council, *Diet and Health: Implications for Reducing Chronic Disease Risk*, National Academy Press, 1989.

[17] U.S. Public Health Service, *The Surgeon General's Report on Nutrition and Health*, U.S. Department of Health and Human Services, 1998, DHHS publication no. (PHS) 88-50210.

[18] Troccoli, K. B., *Eat to Learn, Learn to Eat: The Link Between Nutrition and Learning in Children*, Washington, DC: National Health/Education Consortium, 1993. A summary appears in: ERIC Clearinghouse on Elementary and Early Childhood Education, "Children's nutrition and learning," *ERIC Digest*, Urbana, Illinois, ED369579, June 1994.

[19] Centers for Disease Control and Prevention, "Guidelines for school health programs to promote lifelong healthy eating," *MMWR*, June 14, 1996, Vol. 45, No. RR–9.

[20] Remarks of Agriculture Secretary Dan Glickman at the USDA Symposium on Childhood Obesity: Causes and Prevention, October 17, 1998, in U.S. Department of Agriculture, *Childhood Obesity: Causes and Prevention: October 17, 1998 Symposium Proceedings*, April 1999, p.63.

[21] Troiano,R., and Flegal, K., "Overweight children and adolescents: Description, epidemiology, and demographics," *Pediatrics*, 1998; 101: 497–504.

[22] Fagot-Campagna, A. et al., "Type 2 diabetes among North American children and adolescents: An epidemiological review and a public health perspective," *Journal of Pediatrics* (submitted).

[23] Pinhas-Hamiel, O. et al., "Increased incidence of non-insulin-dependent diabetes mellitus among adolescents," *Journal of Pediatrics*, 1996; 128: 608–615.

[24] Koop, C.E., "Shape Up America 1996 Annual report, Message from the Chairman." Available at www.shapeup.org.

[25] Centers for Disease Control and Prevention, Youth Risk Behavior Survey, 1997, unpublished data.

[26] American Psychiatric Association Task Force on DSM-IV, *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV*, American Psychiatric Association, 1994.

[27] Contento, I. et al., "The effectiveness of nutrition education and implications for nutrition education policy, programs, and research: A review of the research," *Journal of Nutrition Education*, 1995; 27(6): 280.

[28] Collins, J. et al., "School health education," *Journal of School Health*, 1995; 65(8): 302–311.

[29] "School-Based Nutrition Programs and Services," position paper of the American Dietetic Association (ADA), adopted on October 16, 1994.

[30] Allegrante, J.P., "School-site health promotion for staff." In Marx, E. and Wooley, S.F., *Health Is Academic*, New York: Teachers College Press, 1998, p. 224–243.

[31] Blair, S.N. et al., "Health promotion for educators: Effect on health behaviors, satisfaction, and general well-being," *American Journal of Public Health*, 1984; 74: 147–149.

[32] Allegrante, J.P, and Michela, J.L., "Effect of a school-based workplace health promotion program on morale of inner-city teachers," *Journal of School Health*, 1990; 60: 25–28.

[33] Baxter, S., "Are elementary schools *teaching* children to prefer candy but not vegetables?" *Journal of School Health*, 1998 68(3): 111–113.

[34] Wolfe, W.S. and Campbell, C.C., "Nutritional health of school-aged children in upstate New York: what are the problems and what can schools do?" Cornell University Division of Nutritional Sciences, 1991.

[35] Consumers Union, "Captive kids: A report on commercial pressures on kids at school," 1998. View the report at www.igc.org/consunion/other/captivekids.

[36] Food Research and Action Center, "National School Lunch Program." Available at www.frac.org.

[37] Pateman, B., et al., "School food service," *Journal of School Health*, 1995; 65(8): 327–332.

[38] Food Research and Action Center, "United States profile." Available at www.frac.org.

[39] Minnesota Department of Children, Families, and Learning, *School Breakfast Programs, Energizing the Classroom: A Summary of the Three Year Study of the Universal School Breakfast Pilot Program in Minnesota Elementary Schools*, March 1998. Available by calling (612) 296-6986 or download the report at http://cfl.state.mn.us/FNS/FNS.HTM.

[40] Food Research and Action Center, "School breakfast scorecard: 1999."

[41] Food Research and Action Center, "Summer Food Service Program for Children." Available at www.frac.org.

[42] Burghardt., J. et al., *The School Nutrition Dietary Assessment Study*, U.S. Department of Agriculture, 1993.

[43] "School lunches getting less healthy," *USA Today*, March 23, 1999.

[44] U.S. Department of Agriculture, Instruction 765-3, Food and Nutrition Service.

[45] Centers for Disease Control and Prevention, School Health Policies and Programs Study, 1994 (unpublished data).

[46] Story, M. et al., "Availability of foods in high schools: Is there cause for concern?" *Journal of the American Dietetic Association*, 1996; 96(2): 123–126.

[47] Parcel, G.S., et. al. "School promotion of healthful diet and exercise behavior: An integration of organizational change and social learning theory interventions," *Journal of School Health*, 1987; 57: 150–156.

[48] U.S. Department of Agriculture, "National school lunch program and school breakfast program nutrition objectives for school meals" (7CFR 210.220), *Federal Register*, June 10, 1994; 30218–30251.

[49] Food and Consumer Service, "National school lunch program and school breakfast program: Compliance with the Dietary Guidelines for Americans and food-based menu systems," Washington, DC: U.S. Department of Agriculture, 1995.

[50] U.S. Department of Agriculture, "Competitive food service" (7CFR, 210.2, 210.12:220.2, and 220.12), *Federal Register*, January 1, 1986.

[51] West Virginia Board of Education, "Standards for School Nutrition," Policy 4321.1.

[52] California Education Code, section 39876.

[53] California Code of Regulations, Title 5, sections 15500 and 15501.

[54] Borrud, L. et.al., "What we eat: USDA surveys food consumption changes," *Community Nutrition Instruction*, April 18, 1997: 4–5.

[55] Office of Analysis and Evaluation, Food and Nutrition Service, "School food purchase study: Final report," U.S. Department of Agriculture, 1998.

[56] Subar, A.F. et al., "Dietary sources of nutrients among U.S. children, 1988-91," *Pediatrics*, 1998; 102(4): 913–923.

[57] Munoz, K.A. et al., "Food intakes of U.S. children and adolescents compared with recommendations," *Pediatrics*, 1997; 100: 323–329.

[58] Jacobson, M., *Liquid Candy: How Soft Drinks are Harming Americans' Health*, Center for Science in the Public Interest, undated.

[59] Morton, J.F. and Guthrie, J.F., "Changes in children's total fat intakes and their food group sources of fat, 1989–91 versus 1994–95: Implications for diet quality," *Family Economics and Nutrition Review*, 1998; 11(3): 44–57.

[60] Harnack, L. et al., "Soft drink consumption among U.S. children and adolescents: Nutritional consequences," *Journal of the American Dietetic Association*, 1999; 99(4): 436–441.

[61] French, S.A, et al., "A pricing strategy to promote low-fat snack choices through vending machines," *American Journal of Public Health*, May 1997; 87(5) :849–51.

[62] French, S.A. et al., "Pricing strategy to promote fruit and vegetable purchase in high school cafeterias," *Journal of the American Dietetic Association*, 1997; 97(a): 1008–1010.

[63] National Association of State Boards of Education, "Corporate involvement in schools," Resolution 3.E. adopted by the membership in October, 1998.

[64] American Academy of Child and Adolescent Psychiatry, "Teenagers with eating disorders," fact sheet available at www.aacap.org/factsfam/eating.htm.

[65] Story, M., "School-based approaches for preventing and treating obesity," *International Journal of Obesity*, 1999; 23: S43–S51.

[66] American Dietetic Association (ADA), Society for Nutrition Education (SNE), and American School Food Service Association (ASFSA), "School-based nutrition programs and services," joint position paper, *Journal of the American Medical Association*, 1993; 93: 334–336.

F. Policies to Discourage Tobacco Use

Schools can and must play an essential role in communicating to young people a tobacco-free message through school policies, health education programs, and the day-to-day interactions between staff and students. Adoption of a tobacco-free policy broadcasts a powerful message to students, staff, parents, and the community that school leaders consider the issue important. This chapter provides guidance on developing a comprehensive, integrated policy aimed at discouraging young people from taking up tobacco use and encouraging current tobacco users to quit.

The Centers for Disease Control and Prevention (CDC) has found that clearly articulated school policies, applied fairly and consistently, can help students decide not to use tobacco.[2] Studies demonstrate that the policies that are most effective in reducing tobacco use among students prohibit tobacco use on school property, require prevention education, and provide access to cessation programs rather than solely relying on punitive sanctions for tobacco use at school.[2] Linking school tobacco prevention efforts to the family and the community further reinforces a consistent message against tobacco use.

The Most Important Issue

Smoking is the chief, single avoidable cause of death in our society and the most important public health issue of our time.

—C. Everett Koop, former U.S. Surgeon General[1]

A comprehensive policy should frame tobacco use as not simply a discipline problem but rather as a serious health issue that needs to be addressed by the educational system.

The sample policy in this chapter is designed to discourage tobacco use in multiple ways and in a coordinated fashion. The sample policy:

- defines the purpose and goals of tobacco-use prevention efforts;
- links effective prevention education and a strictly tobacco-free environment;
- addresses staff and visitors as well as students;
- identifies actions to be taken to help students and staff overcome tobacco addiction; and
- promotes good coordination of effort among all those concerned with its implementation.

The sample policy incorporates statements of recommended practice that all states, school districts, and schools should endeavor to adopt. What is reasonable, feasible, and acceptable in a given state, district, or school depends on local circumstances and the results of the policymaking process.

Adopting sound policy is just a start. A comprehensive policy to prevent tobacco use is more likely to be smoothly implemented and consistently enforced if it receives strong administrative support and if all staff, not just health teachers and the school nurse, receive an orientation to the policy and the rationale behind it. These leadership actions can convey the importance of tobacco-use prevention to staff and encourage them to incorporate messages against tobacco use in their interactions with students.

The sample tobacco-use prevention policy is divided into four parts, as listed below. A discussion section that provides supportive information and a concise list of key resources follow each part of the policy.

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2. Tobacco-Free Environments F-11
3. Tobacco-Use Prevention Education F-19
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1. Purpose and Goals

A strong statement of purpose and goals provides a firm foundation for a sound policy. It justifies the policy to staff and the public, communicates policymakers' priorities, and helps guide program implementation.

Sample Tobacco-Use Prevention Policy, Part One:

INTENT. All students shall possess the knowledge and skills necessary to avoid all tobacco use, and school leaders shall actively discourage all use of tobacco products by students, staff, and school visitors. To achieve these ends, *district/school* leaders shall prepare, adopt, and implement a comprehensive plan to prevent tobacco use that includes:

- a sequential educational program to prevent tobacco use that is integrated within the school health education curriculum; that is aimed at influencing students' attitudes, skills, and behaviors; and that is taught by well-prepared and well-supported staff;
- establishment and strict enforcement of completely tobacco-free school environments at all times;
- prohibition of tobacco advertising;
- appropriate counseling services and/or referrals for students and staff to help them overcome tobacco addiction;
- cooperation with community-wide efforts to prevent tobacco use; and
- strategies to involve family members in program development and implementation.

RATIONALE. Cigarette smoking is considered the chief preventable cause of premature disease and death in the United States. Schools have a responsibility to help prevent tobacco use for the sake of students' and staff members' health and the well-being of their families. Research conclusively proves that:

- regular use of tobacco is ultimately harmful to every user's health, directly causing cancer, respiratory and cardiovascular diseases, adverse pregnancy outcomes, and premature death;
- second-hand smoke is a threat to the personal health of everyone, especially persons with asthma and other respiratory problems;
- nicotine is a powerfully addictive substance;
- tobacco use most often begins during childhood or adolescence;

- the younger a person starts using tobacco, the more likely he or she will be a heavy user as an adult; and
- many young tobacco users will die an early, preventable death because of their decision to use tobacco.

Additional reasons why schools need to strongly discourage tobacco use are that:

- the purchase and possession of tobacco products is illegal for persons under age 18 [*depending on the state*];
- use of tobacco interferes with students' attendance and learning;
- smoking is a fire safety issue for schools; and
- use of spit tobacco is a health and sanitation issue.

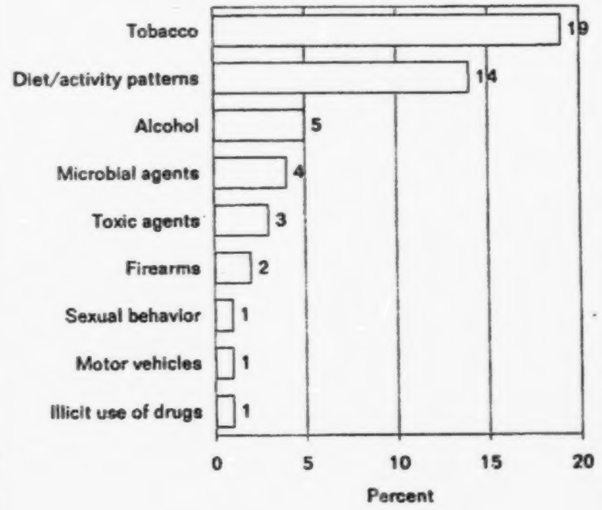
DEFINITION. For the purposes of this policy "tobacco" is defined to include any lighted or unlighted cigarette, cigar, pipe, bidi, clove cigarette, and any other smoking product, and spit tobacco, also known as smokeless, dip, chew, and snuff, in any form.

Discussion

Tobacco addiction has very serious consequences for families and society as a whole. Tobacco use is the leading preventable cause of death in the United States; it causes more than 400,000 deaths each year and results in more than $50 billion annually in direct medical costs. Each year, smoking kills more people than AIDS, alcohol, drug abuse, car crashes, murders, suicides, and fires *combined*.[4] As greater than 80 percent of adult smokers started smoking before the age of 18,[5] there is a powerful argument that schools need to do everything possible to

Chart 1

Actual Causes of Death, United States, 1990



—McGinnis and Foege[3]

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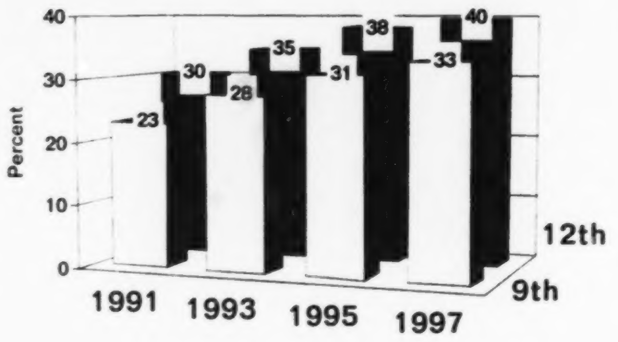
actively discourage the use of tobacco products.

The Youth Risk Behavior Survey (YRBS), conducted by CDC every two years, found that 33 percent of ninth graders were current smokers in 1997.[6] The percentage increased with each additional grade level to the point where 40 percent of all high school seniors smoke (see Chart 2, "Increases in Youth Smoking"). The chart also shows that the percentage of students who smoke cigarettes increased through the 1990s.

Chart 2

Increases in Youth Smoking

Percentage of students in grade nine and grade twelve who smoked cigarettes on one or more of the previous 30 days, 1991–97



—Centers for Disease Control and Prevention[6]

The rate of tobacco use by students has been nearly the same for young men and women, except that black females are much less likely than black males to report smoking— 17 percent versus 28 percent in 1997. Both black females and black males have smoking rates that are lower than those of white students.[6]

Of particular concern to educators is the finding that nearly 15 percent of all high school students had smoked cigarettes *while on school property* in the 30 days before the survey.[6]

"Spit" Tobacco

The often-used term "smokeless tobacco" originated in marketing efforts by the tobacco industry to imply that chewing tobacco is a safe alternative to smoking it. The substitute term "spit tobacco" is increasingly being used in the public health arena, in part because of the distasteful image it conveys.

Furthermore, the YRBS found that more than 20 percent of white male high school students used spit tobacco on a regular basis; the prevalence in this group is much higher than for all other ethnic and gender groups.[6] More than 11 percent of white male students had used spit tobacco while on school property.[6]

In another national survey, 37 percent of males and 16 percent of females ages 14–19 reported they had smoked a cigar in the past year.[7]

Tobacco and other substance use

Although a cause-and-effect relationship has not been demonstrated, data collected by CDC show that teens who smoke are three times more likely than nonsmokers to use alcohol, eight times more likely to use marijuana, and 22 times more likely to use cocaine.[4] Tobacco use is strongly associated with use of other substances and often occurs at an earlier age than other drug use.[8] Some students report taking up

A Decision Made as a Child

Today, nearly 3,000 young people across our country will begin smoking regularly. Of these 3,000 young people, 1,000 will lose that gamble to the diseases caused by smoking. The net effect of this is that among children living in America today, five million will die an early preventable death because of a decision made as a child.

—Donna E. Shalala, Secretary
U.S. Department of Health
and Human Services[1]

smoking to enhance the effects of marijuana.[10]

The 1994 Surgeon General's report notes that use of tobacco is also associated with delinquency, low scholastic achievement, and a host of other risky behaviors, including fighting, carrying weapons, attempting suicide, and engaging in early and unprotected sex:

> These problem behaviors can be considered a syndrome, since involvement in one behavior increases the risk for involvement in others. Delaying or preventing the use of tobacco may have implications for delaying or preventing these other behaviors as well.[5]

A student's use of tobacco might be an observable symptom— a red flag— of other problems that could seriously affect school performance. At a time when schools are under tremendous pressure to ensure that all children achieve to high standards, addressing every potential barrier to learning is very much the school's job.

Major Conclusions of the Surgeon General's 1994 Report

Nearly all first use of tobacco occurs before high school graduation; this finding suggests that if adolescents can be kept tobacco-free, most will never start using tobacco.

Most adolescent smokers are addicted to nicotine and report that they want to quit but are unable to do so; they experience relapse rates and withdrawal symptoms similar to those reported by adults.

Tobacco is often the first drug used by those young people who use alcohol, marijuana, and other drugs.

Adolescents with lower levels of school achievement, with fewer skills to resist pervasive influences to use tobacco, with friends who use tobacco, and with lower self-images are more likely than their peers to use tobacco.

Cigarette advertising appears to increase young people's risk of smoking by affecting their perceptions of the persuasiveness, image, and function of smoking.

Community-wide efforts that include tobacco tax increases, enforcement of minors' access laws, youth-oriented mass media campaigns, and school-based tobacco-use prevention programs are successful in reducing adolescent use of tobacco.

—U.S. Surgeon General[5]

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Guidelines from CDC

CDC's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction* were developed in collaboration with experts from 29 national, federal, and volunteer agencies and are based on an extensive review of research and practice. The guidelines include seven recommendations for ensuring a quality school program to prevent tobacco use:

1. POLICY: *Develop and enforce a school policy on tobacco use.* The policy—developed in collaboration with students, parents, school staff, health professionals, and school boards—should

- Prohibit students, staff, and visitors from using tobacco on school premises, in school vehicles, and at school functions.
- Prohibit tobacco advertising (e.g., on signs, T-shirts, or caps or through sponsorship of school events) in school buildings, at school functions, and in school publications.
- Require that all students receive instruction on avoiding tobacco use.
- Provide access and referral to cessation programs for students and staff.

2. INSTRUCTION: *Provide instruction about the short- and long-term negative physiologic and social consequences of tobacco use, social influences on tobacco use, peer norms regarding tobacco use, and refusal skills.* This instruction should

- Decrease the social acceptability of tobacco use and show that most young people do not smoke.
- Help students understand why young people start to use tobacco and identify more positive activities to meet their goals.
- Develop students' skills in assertiveness, goal setting, problem solving, and resisting pressure from the media and peers to use tobacco.

Programs that only discuss tobacco's harmful effects or attempt to instill fear do not prevent tobacco use.

3. CURRICULUM: *Provide tobacco-use prevention education in grades K–12.*

- This instruction should be introduced in elementary school and intensified in middle/junior high school, when students are exposed to older students who typically use tobacco at higher rates.
- Reinforcement throughout high school is essential to ensure that successes in preventing tobacco use do not dissipate over time.

4. STAFF TRAINING: *Provide program-specific training for teachers.* The training should include reviewing the curriculum, modeling instructional activities, and providing opportunities to practice implementing the lessons.

Well-prepared student peer leaders can be an important adjunct to teacher-led instruction.

5. FAMILY INVOLVEMENT: *Involve parents or families in support of school-based programs to prevent tobacco use.* Schools should

- Promote discussions at home about tobacco use by assigning homework and projects that involve families.
- Encourage parents to participate in community efforts to prevent tobacco use and addiction.

6. TOBACCO CESSATION EFFORTS: *Support cessation efforts among students and school staff who use tobacco.* Schools should provide access to cessation programs that help students and staff stop using tobacco rather than punishing them for violating tobacco-use policies.

7. EVALUATION: *Assess the tobacco-use prevention program at regular intervals.* Schools can use CDC's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction* to assess whether they are providing effective policies, curricula, training, and cessation programs.

—Centers for Disease Control and Prevention[2]

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Resources

- Your state and local education agencies and health departments can be valuable sources of statistical information, advocacy materials, policy referrals, details about state law, and technical assistance for program planning.

- The CDC **Division of Adolescent and School Health** (DASH) offers a variety of materials and support services for schools, including:

    - *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction*, cited throughout this chapter; and

    - assistance in implementing the Youth Risk Behavior Survey (YRBS), a nationwide system for collecting data on youth behaviors. An easy-to-use CD-ROM of national and state summary data is available to examine youth risk behaviors and trends over time in six risk categories, including tobacco use.

    Write to: CDC Division of Adolescent and School Health, 4770 Buford Highway, NE, Mail Stop K-32, Atlanta, GA 30341-3717;
    telephone: (770) 488-3168;
    FAX (770) 488-3111;
    e-mail ccdinfo@cdc.gov; or
    go to www.cdc.gov/nccdphp/dash.

- The **National Association of State Boards of Education** (NASBE) and the **National Schools Boards Association** (NSBA) both operate school health resource databases that contain many sample policies. NASBE's database focuses on state-level policies, and NSBA has compiled a large number of school district policies and support documents. NSBA has also compiled excerpts from key documents and sample district policies in a *Tobacco Prevention 101* packet. Both organizations can provide up-to-date information on policy topics, information on people's experiences in implementing policies, consultation on specific policy issues, and referrals to other experts in the field.

    - Contact NASBE at (703) 684-4000 or boards@nasbe.org.

    - Contact NSBA at 703-838-6722 or schoolhealth@nsba.org.

- CDC's **Office on Smoking and Health** (OSH) directs the U.S. government's tobacco and health activities. It collects and distributes smoking and health information in a variety of forms, including pamphlets, posters, scientific research reports, national campaigns, and public service announcements. Among its publications is *Best Practices for Comprehensive Tobacco Control Programs* (1999), which contains specific advice for school programs and budgets. Call (770) 488-5705 for general information and publication requests, or (800) CDC-1311 for the automated campaign response line and FAX service in English and Spanish.

- OSH's **Tobacco Information and Prevention Source** (TIPS) website offers a wealth of data and links to other useful sites. TIPS includes a link to the CDC Smoking and Health Database, which contains abstracts of journal articles, books and book chapters, dissertations, reports, conference proceedings and conference papers, government documents, policy and legal documents, editorials, letters, and comments on articles. Go to www.cdc.gov/tobacco.

- The **U.S. Surgeon General**'s office has published two landmark reports of interest to those developing school health policies: *Preventing Tobacco Use Among Young People* (1994) and *Tobacco Use Among U.S. Racial/Ethnic Minority Groups* (1998). Limited copies are available by calling (202) 512-1803. Executive summaries of the reports are online at www.cdc.gov/tobacco/sgrpage.htm.

- The **Institute of Medicine** (IOM) of the National Academy of Sciences published *Growing Up Tobacco-Free: Preventing Nicotine Addiction in Children and Youths* (1994), which provides a readable explanation of nicotine's effects, the process of addiction, and effective prevention approaches. Write to National Academy Press, 2101 Constitution Avenue, Washington, DC 20418.

- The **National Clearinghouse for Alcohol and Drug Information** (NCADI) provides information about the health risks of using addictive drugs, including tobacco. Call (800) Say-No-To or go to www.health.org.

- **The National Cancer Institute** (NCI) produces information on the health effects of tobacco use that is available to the general public. Call (800) 4-CANCER or go to www.nci.nih.gov.
- **The National Heart, Lung, and Blood Institute** (NHLBI) serves as a source of information and public education materials on risk factors for cardiovascular disease. Call (301) 251-1222 or go to www.nhlbi.nih.gov/nhlbi/nhlbi.htm.
- **The Environmental Protection Agency** (EPA) offers publications and information on the adverse effects of secondhand smoking. Call the Indoor Air Quality Information Clearinghouse at (800) 438-4318 or go to www.epa.gov/iaq.
- **The Tobacco BBS** website contains current news and a comprehensive collection of Internet links to government agencies, nonprofit organizations, and tobacco control activists. Go to www.tobacco.org.

Note

The organizations included as resources in this guide offer a broad range of assistance, have a national scope, are easily accessed, have materials available at low or no cost, and/or offer specialized expertise. The lists are not exhaustive. Scores of other organizations provide high-quality assistance and advice to educators; hundreds of informative books and articles are available. Consider the resources listed here as starting points.

2. Tobacco-Free Environments

The school environment is a persuasive teacher: it can demonstrate and support the lessons taught in the classroom, or it can contradict and discount those lessons. A tobacco-free environment is fundamental to any school effort designed to prevent or reduce tobacco addiction in young people. Policymakers should take a firm stand that the use of tobacco is strictly prohibited on school grounds by anyone and at all times.

Sample Tobacco-Use Prevention Policy, Part Two:

TOBACCO USE PROHIBITED. No student, staff member, or school visitor is permitted to smoke, inhale, dip, or chew tobacco at any time, including non-school hours:

- in any building, facility, or vehicle owned, leased, rented, or chartered by the *state/district/school;*
- on school grounds, athletic grounds, or parking lots; or
- at any school-sponsored event off campus.

In addition, no student is permitted to possess a tobacco product. The provisions of existing policies that address the use and possession of drugs shall apply to all tobacco products.

TOBACCO PROMOTION. Tobacco promotional items, including clothing, bags, lighters, and other personal articles, are not permitted on school grounds, in school vehicles, or at school-sponsored events. Tobacco advertising is prohibited in all school-sponsored publications and at all school-sponsored events.

CLOSED CAMPUS. No student may leave the school campus during breaks in the school day to use a tobacco product. Signs to this effect will be posted at appropriate locations. School authorities shall consult with local law enforcement agencies to enforce laws that prohibit the possession of tobacco by minors within the immediate proximity of school grounds.

NOTICE. The *superintendent/principal/other* shall notify students, families, education personnel, and school visitors of the tobacco-free policy in handbooks and newsletters, on posted notices or signs at every school entrance and other appropriate locations, and by other efficient means. To the extent possible, schools and districts will make use of local media to publicize the policies and help influence community norms about tobacco use.

ENFORCEMENT. It is the responsibility of all students, employees, and visitors to enforce this policy through verbal admonition. Any tobacco product found in the possession of a minor student shall be confiscated by staff and discarded. Students and employees also may be subject to germane sanctions as determined by written school policy, including disciplinary action. All school staff shall participate in training on the correct and fair enforcement of tobacco-free policies.

Discussion

A strict, rigorously enforced tobacco-free environment policy protects children from the hazards of exposure to tobacco smoke at school. Environmental tobacco smoke has been classified as a "group A" known human carcinogen, the same classification as asbestos and benzene. Nonsmokers who are subjected to environmental tobacco smoke are exposed to nicotine, carbon monoxide, and cancer-causing agents.[11] Each year in the United States more than 53,000 deaths are attributed to second-hand smoke (see box below, "Health Consequences of Second-Hand Smoke").[12]

Health Consequences of Second-Hand Smoke

- **Causes lung cancer in nonsmokers;**
- **associated with higher death rates from cardiovascular disease in nonsmokers;**
- **in children, associated with respiratory tract infections, increased prevalence of fluid in the middle ear, additional episodes of asthma, increased severity of symptoms in children with asthma, and a risk factor for onset of asthma in children who have not previously displayed symptoms;**
- **associated with increased risk of sudden infant death syndrome (SIDS); and**
- **associated with increased irritant effects, particularly eye irritation, among allergic persons.**

—CDC Office on Smoking and Health[11]

Prohibiting the use of tobacco in school buildings, on school grounds, and at school-sponsored events significantly reduces opportunities for young people to experiment with smoking and chewing. It can also reduce their access to tobacco, as many exchanges of tobacco products are made on school grounds when students are smoking or using spit tobacco with friends.

In addition, states, districts, and schools may realize financial benefits from a tobacco-free environment policy. Costs for fire insurance, building maintenance, and staff health insurance might decrease.[11] Student and staff absenteeism rates might decrease as well (see box, "Benefits of a Smoke-Free Workplace," on the following page). Yet, a 1994 national survey found that only 59 percent of states recommended that schools develop tobacco-use policies that create completely smoke-free environments, and only 47 percent of local school districts had such policies.[13]

Some tobacco-free environment policies, including the sample policy in this section, prohibit students' *possession* of any tobacco product, not just its use. In at least 19 states minors can be fined for possession of tobacco.[14] Such a prohibition not only

Benefits of a Smoke-Free Workplace

- A smoke-free environment helps create a safe, healthful workplace.
- Direct health care costs to the company may be reduced.
- Excess smoking-related absenteeism among smokers who are motivated to quit may be reduced.
- Maintenance costs go down when smoke, matches, and cigarette butts are eliminated in facilities.
- Office equipment, carpets, and furniture last longer.
- It may be possible to negotiate lower health, life, and disability coverage as employee smoking is reduced.
- The risk of fires is lower.

—CDC Office on Smoking and Health[11]

might reduce access to tobacco but also could make policy enforcement easier.

A comprehensive tobacco-free environment policy should also ban possession of tobacco promotional items (e.g., T-shirts, hats, backpacks, jackets, lighters, camping gear, electronics) on school grounds. These items are highly visible in the school setting, and their ownership is strongly associated with initiation and maintenance of smoking behavior.[16]

Closed campus policies can help reduce students' opportunities to use tobacco during the school day. See page E-35 in the earlier chapter on "Policies to Promote Healthy Eating" for a discussion of how students can be mobilized to help move a school toward a closed-campus policy. Schools are advised to coordinate monitoring and enforcement strategies with their local police departments for consistent implementation of youth tobacco-use prevention policies on and off the school campus.

The Pro-Children Act

In 1994 the U.S. Congress passed the Pro-Children Act, which requires that smoking be prohibited in any indoor facility that is used for "provision of routine or regular kindergarten, elementary, or secondary education or library services to children" if the services are supported by any federal funds. Federal grant applicants must now certify that they are complying with this law. The Act helps to ensure that children are not exposed to second-hand smoke at school.

The Right Thing to Do

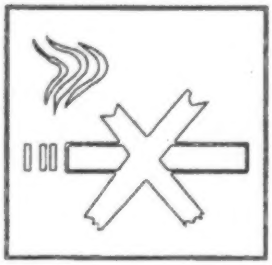
Establishing a totally tobacco-free school environment is not always the easiest thing to do, but it is the right thing to do to protect children and help them develop into healthy adults.

—Colorado ASSIST Alliance[15]

However, the Pro-Children Act does not mandate completely tobacco-free school environments: it applies only to tobacco products that are smoked and to indoor facilities that are used by children. States, districts, and schools are free to go beyond the provisions of this Act; many have already done so. A 1994 national survey found that 82 percent of school districts prohibit students from smoking in school buildings and on school grounds at all times.[13]

Enforcement

A range of possible consequences exists for students who are caught violating tobacco policies. A sound enforcement strategy includes a number of alternatives to suspension or expulsion from school. Administrators should be able to choose a response from a list of punishing and helping consequences that is appropriate to the violation and the individual student.



Punishment options might include some combination of:

- referral to a school counselor or administrator;
- parental notification and/or conference;
- requirement to perform community service, such as litter pick-up;
- suspension or expulsion from athletic and other extracurricular activities;
- revocation of parking or other privileges;
- substantial fines;
- detention or in-school suspension;
- assignment to alternative schools or after-school programs; or
- police notification, prosecution, or referral to an alternative adjudication or diversion program.

A useful menu of consequences should also include constructive helping options for several reasons. Some school administrators might consider tobacco use not serious enough to warrant disciplinary action and so might avoid applying sanctions on students, regardless of what a policy directs. Others might have concerns about the effectiveness of policies that rely primarily on punishment. Punitive sanctions can sometimes backfire by stoking rebellious attitudes among youth; lingering resentments can detract from a positive learning environment.

Some administrators approach a tobacco policy violation as a health issue rather than a school discipline issue and apply consequences that are intended to enhance the violator's awareness of the effects of tobacco use. Health-enhancing disciplinary actions might include the following:

- written assignments on the health effects of tobacco use;

Schools Can Prosecute

Act 145 [of 1996] amends the [Pennsylvania] Crimes Code to prohibit students from both possessing and using tobacco products in school buildings, on school buses, and on school property.... School districts now have the authority to initiate prosecution for student violations, rather than relying on municipalities to do so. Convicted students will be found guilty of a summary offense. The court may fine guilty students up to $50 plus court costs or may admit them to an adjudication alternative instead of a fine. Collected fines will benefit the school district.

—Pennsylvania School Boards Association[17]

A Delicate Balance

Several criticisms have been received to the effect that the new [strict anti-tobacco] law, and any policies adopted in response thereto, will turn schools away from the business of educating students and into law enforcement agencies. This is neither the intent of the law nor need it be implemented in such a manner as to bring about that result. Nonetheless, a delicate balance must be struck. Education is the paramount function of schools, and trust must exist between educators and students. At the same time, duly enacted laws must be observed, respected, and enforced.... We suggest that meetings be conducted with local law enforcement officials....

Questions have been raised about the ability of a school board to prohibit students over the age of 18 from possessing tobacco on school grounds. While it is generally legal for a person over the age of 18 to possess tobacco, that does not give a person enrolled as a student the right to violate school policies in this regard. For example, a student over the age of 18 could not possess a weapon or alcohol at school in violation of a school policy even though possession of weapons or alcohol might be legal in other contexts.

—Vermont State Board of Education[11]

- community service related to tobacco-use prevention;
- educational classes that emphasize building social skills to resist using tobacco;
- encouragement to participate in tobacco-use cessation programs; or
- referrals to a student assistance program because smoking might be an indicator of other problems that could put the student at risk for school failure.

Any policy must be enforced consistently and equitably as students are keen perceivers of unfairness. Repeat offenders should repeatedly incur consequences to reinforce the "no tobacco use" message and encourage them to quit using tobacco. Yet a sound enforcement policy also allows school officials to exercise discretion on a case-by-case basis and provides avenues for appeal.

Students themselves can be invited to suggest appropriate monitoring schemes, enforcement mechanisms, and consequences for policy violations. Peer self-enforcement and student courts can be useful tools in the fight against tobacco use.

Adult tobacco use on school grounds

Children learn to smoke not only from peers but also by imitating adults. Staff members and visitors who use tobacco on school grounds are poor role models for children and adolescents. Whether or not they intend to, these adults inevitably influence students' attitudes by suggesting it is a responsible adult decision to use a tobacco product. Unfortunately, the 1994 national survey cited earlier found that fewer than half of all middle schools and high schools prohibit tobacco use for both students *and staff* on school grounds at all times.[13]

To provide the healthiest environment with the fewest cues to use tobacco, schools must prohibit all adult use of tobacco in buildings, on grounds, and at school-sponsored events at all times. This includes teachers, bus drivers, cafeteria workers, maintenance staff, athletic spectators,

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school visitors, and even community members who play Bingo in the evening.

Allowing smoking areas on campus, even if only for the use of staff, creates an aura of official school acceptance.[19] Although the use and possession of tobacco products by adults is lawful, this does not confer any legally enforceable "smokers' rights" that override the ability of a school to ensure a healthy learning climate. Policymakers should be firm about tobacco-free policies even if it becomes an issue in contract negotiations. Appropriate responses for education personnel found violating a ban on tobacco might include:

- conference with supervisor;
- referral to an employee assistance program; or
- disciplinary action consistent with applicable personnel policies.

A Mixed Message

Policies restricting smoking that are selectively applied may be ineffective and may send a mixed message. For instance, a school-based policy that enforces the legal ban on tobacco use by students, but allows the legal use by teachers and staff, sends the message that tobacco use among adults is acceptable.

—U.S. Center for Substance Abuse Prevention[20]

Tobacco-Free Workplace Policy

It is the intent and philosophy of the district to continue to provide an environment which encourages and supports employees in their efforts to lead healthy lives by providing them with a tobacco-free work environment....

It is the belief of the Hacienda La Puente Unified School District that employees should serve as role models to students and demonstrate good health practices that are consistent with school programs and which are intended to discourage students from using tobacco products....

The superintendent or a designee shall post at each site and provide each employee with a notice that the unlawful use of tobacco is prohibited in the workplace. This notice shall also:

a. Include a statement of possible disciplinary actions. The discipline shall be in accordance with board policies on discipline, the Education Code, and applicable collective bargaining agreements.

b. Inform employees of the availability of counseling, rehabilitation, and employee assistance programs.

c. Inform employees that as a condition of employment, each employee must abide by the terms of this policy.

d. Notify employees of the district's policy of maintaining a tobacco-free workplace.

e. Inform employees of the dangers of tobacco use in the workplace, including, but not limited to, threats to the health and safety of employees, students, and the public.

—Hacienda La Puente Unified School District, California[21]

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Resources

- *Making Your Workplace Smoke-Free: A Decision Maker's Guide* from CDC's **Office on Smoking and Health** (OSH) contains information on how to design, implement, and evaluate environmental tobacco smoke policies and related activities. Available at www.cdc.gov/nccdphp/osh/ etsguide.htm.

- **School Health Resources Services** at the University of Colorado Health Sciences Center offers a comprehensive resource packet on tobacco-free schools. Contact (303) 270-5990.

- **Group Against Smokers' Pollution** (GASP) provides educational information and referral services about the health hazards of second-hand smoke and establishment of nonsmoking laws and policies. Contact (301) 459-4791.

- A number of states have developed useful resources, including the following:
    - *Getting to Tobacco-Free Schools: A Trouble-Shooting Guide*, developed by the **Colorado ASSIST Alliance**, contains practical suggestions on policy development and enforcement. It is available from the Colorado Department of Public Health and Environment at (303) 692-2510.
    - *Creating and Maintaining a Tobacco-Free School Policy* is available through the Bureau of Health, **Maine Department of Human Services** at (207) 287-4625.
    - The *Grass Roots Guide for Tobacco-Free Schools* by the **North Carolina Department of Health and Human Services** is available at (919) 733-1340.
    - *Guidelines for Implementation of West Virginia Board of Education Policy 2422.5A: Tobacco Control* is available from the **West Virginia Department of Education** at (304) 558-8830.

3. Tobacco-Use Prevention Education

A sound policy on preventing tobacco use emphasizes that the educational program must provide students with the necessary *skills* to resist social influences to use tobacco. Teaching facts or relying on scare tactics are not effective methods without a skills component.

Sample Tobacco-Use Prevention Policy, Part Three:

INSTRUCTIONAL PROGRAM DESIGN. Tobacco-use prevention education shall be integrated within the health education program and be taught at every grade level, pre-kindergarten through twelfth. The educational program shall be based on theories and methods that have been proven effective by published research and consistent with the *state's/district's/school's* health education *standards/guidelines/framework*. The program shall be designed to:

- instruct about immediate and long-term undesirable physiologic, cosmetic, and social consequences of tobacco use;
- decrease the social acceptability of tobacco use;
- address reasons why young people smoke;
- teach how to recognize and refute advertising and other social influences that promote tobacco use;
- develop students' skills for resisting social influences that promote tobacco use; and
- develop necessary assertiveness, communication, goal-setting, and problem-solving skills that may enable students to avoid tobacco use and other health-risk behaviors.

Instruction shall be most intensive in grades six through eight and shall be reinforced in all later grades. Instructional activities shall be participatory and developmentally appropriate. The program shall engage families as partners in their children's education.

STAFF PREPARATION. Staff responsible for teaching tobacco-use prevention shall have adequate preservice training and participate in ongoing professional development activities to effectively deliver the education program as planned. Preparation and professional development activities shall provide basic knowledge about the effects of tobacco use combined with skill practice in effective instructional techniques and strategies and program-specific activities.

EDUCATIONAL REINFORCEMENT. Tobacco-use prevention education shall be closely coordinated with the other components of the school health program. Tobacco-use prevention concepts shall also be integrated into the instruction of other subject areas to the greatest extent possible.

To send consistent messages to students and their families, school instructional staff shall collaborate with agencies and groups that conduct tobacco-use prevention education in the community. Guest speakers invited to address students shall receive appropriate orientation to the relevant policies of the _school/district_. School staff shall also help interested students become involved with agencies and other organizations in the community that are working to prevent tobacco use.

Discussion

Schools *can* successfully prevent many young people from using tobacco products. According to the U.S. Surgeon General, school-based tobacco prevention programs that help students identify the social influences that promote tobacco use (e.g., peers, media, family members) and then teach skills to resist those influences have demonstrated real reductions or delays in adolescent smoking.[5] In a variety of studies, differences in smoking prevalence between students who participate in such programs and control groups range from 25 to 60 percent, and those differences persisted for one to four years. Positive results have been shown across programs that vary in format, scope, and delivery methods in a variety of community cultures.[2]

Programs to prevent use of spit tobacco that are based on the same model have also demonstrated modest reductions in the initiation of use.[5] In addition, studies have found that the approaches that are effective

Decreasing Instruction Parallels Increasing Use

Most school health instructional programs neglect smokeless tobacco use. In fact, most states even neglect to mandate tobacco prevention education instruction within the comprehensive health education program. Further, the average time mandated for school health instruction decreases with each grade, parallel to when tobacco use increases.

—National Institutes of Health[23]

Youth Underestimate the Addictiveness of Tobacco

- **Among high school seniors, 73 percent of daily smokers who think they won't be smoking daily in five years still are.**
- **Seventy percent of youth (ages 12–17 years) who smoke indicated that they would not have started if they could choose again.**
- **Approximately three-quarters of young people (ages 10–22 years) who use tobacco daily report that they use it because "it's really hard to quit." Findings were the same for cigarette smokers and for smokeless tobacco users.**
- **More than 90 percent of young people (ages 10–22 years) who use tobacco daily experienced at least one symptom of nicotine withdrawal when they tried to quit.**

—Centers for Disease Control and Prevention[22]

in preventing tobacco use also can help prevent the use of alcohol and other drugs.[2]

Although young people need to learn the immediate and long-term negative effects of tobacco use (in particular, the consequences of using spit tobacco are not widely known by students), programs that aim simply to increase knowledge *do not* reduce tobacco use (see box, "Providing Knowledge Is Not Sufficient"). Programs that attempt to induce fear about the consequences of tobacco use are similarly ineffective.[2]

Anti-Drug Programs Should Address Tobacco

Drug prevention programs for youth that address only controlled drugs send an erroneous message that alcohol and tobacco do not present significant problems, or that society is willing to overlook their use. To be credible, messages opposing illegal drug use by youth should address alcohol and tobacco as well.

—Safe and Drug-Free Schools and Communities Act[23]

The CDC, through its Research to Classroom project, works to identify specific curricula that have scientifically credible evidence of reducing health-risk behaviors among students. As of 1999, the Project had identified two curriculum programs that show convincing evidence of reducing tobacco use (see box, "Tobacco-Use Prevention 'Programs That Work,'" on the following page).

Providing Knowledge Is Not Sufficient

Providing knowledge of the health consequences of smoking is a basic and necessary step, but it is not sufficient to change the behavior of most youths, for three reasons. First, the information-deficit model does not address the complex relationship between knowledge acquisition and subsequent behavior. Second, the model does not consider the addictive nature of tobacco use. Third, the model does not address risk factors such as peer use and approval of tobacco and perceived prevalence of peer tobacco use.

Eight structural elements are considered both necessary and sufficient for effective school-based smoking prevention programs.

- **Classroom sessions should be delivered at least five times per year in each of two years in the sixth through eighth grades.**
- **The program should emphasize the social factors that influence smoking onset, short-term consequences, and refusal skills.**
- **The program should be incorporated into the existing school curricula.**
- **The programs should be introduced during the transition from elementary school to junior high or middle school (sixth or seventh grades).**
- **Students should be involved in the presentations and delivery of the program.**
- **Parental involvement should be encouraged.**
- **Teachers should be adequately trained.**
- **The program should be socially and culturally acceptable to each community.**

Of critical importance is the integrity of implementation and the fidelity of instruction. [That is,] the programs should be adopted by schools and used in a manner that is close to the way they were evaluated.

—Institute of Medicine[24]

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Schools can use federal funds provided under the Safe and Drug-Free Schools and Communities Act to support tobacco prevention education. Many states also have funding available for education to prevent tobacco use as a result of recent legal settlements between the tobacco industry and the states.

Instructional strategies

A teaching strategy that often catches students' attention is to point out the immediate, rather than the long-term, effects of tobacco use. The stained teeth and foul-smelling breath and clothes of smokers put off many young people. Additional short- term effects include ostracism by

Tobacco-Use Prevention "Programs That Work"

As part of its Research to Classroom project (see page C-39 in the "General School Health Policies" chapter), CDC has identified two "Programs That Work" to prevent tobacco use. An extensive review process determined that the following curricula had credible evidence of effectiveness.

1. Project Towards No Tobacco Use (Project TNT)

A curriculum for students in seventh and eighth grades, Project TNT has been implemented with white non-Hispanic, Latino, African-American, and Asian-American adolescents. The curriculum contains 10 core lessons for seventh grade classes and two booster lessons for the eighth grade; each lesson lasts 40 to 50 minutes. Project TNT helps students resist using tobacco products by (1) enhancing their awareness of misleading social information that facilitates tobacco use (e.g., advertising), (2) providing them with skills that counteract the social pressures to achieve approval by using tobacco, and (3) teaching them the physical consequences that tobacco use may have on their lives (e.g., the beginnings of addiction).

Compared with the control group, students who participated in Project TNT reduced:

- **initiation of cigarette smoking by approximately 26 percent (when one-year and two-year follow-up outcomes were averaged);**
- **initiation of smokeless tobacco use by approximately 60 percent; and**
- **weekly or more frequent cigarette smoking by approximately 30 percent.**

For students in the Project TNT group, weekly or more frequent use of spit tobacco was eliminated.

2. Life Skills Training (LST)

A curriculum for students in grades six through nine, LST consists of 15 class periods scheduled one or more times per week, with booster sessions of 10 class periods in Year Two and five class periods in Year Three. The program can be integrated into different subject areas, such as health education, science, and drug prevention. The curriculum targets social risk factors such as media influence and peer pressure as well as personal risk factors such as anxiety and low self-esteem.

LST had a significant effect on reducing cigarette, marijuana, and alcohol use after three years for those students whose teachers taught at least 60 percent of the program. There were 44 percent fewer LST students than controls who used tobacco, alcohol, and marijuana one or more times per month, and 66 percent fewer LST students who reported using all three substances one or more times per week. The strongest prevention effects were produced for the students who received the most complete implementation of the LST program, including the two booster sessions. Results of the six-year follow-up indicated that the effects of LST lasted until the end of 12th grade.

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nonsmoking peers, decreased stamina, and the potential to worsen asthma and other respiratory problems. Athletes should be made aware that smoking slows lung growth, decreases lung function, and reduces the oxygen available for the muscles used in sports.[26]

To be most effective, school-based tobacco-use prevention programs must target young people *before* they initiate tobacco use or drop out of school. In addition, without repeated booster sessions in later grades, the effects of even the most successful programs dissipate over time. Based on a rigorous review of program evaluations, CDC's Guidelines for School Health Programs to Prevent Tobacco Use and Addiction recommends that education to prevent tobacco use begin in elementary school, more intensive instruction be conducted in grades six through eight, and reinforcement be provided throughout high school.[2] The guidelines contain a detailed list of instructional concepts according to grade level.

Students often respond positively to "media literacy" lessons that teach them how advertising techniques are used to subtly influence attitudes and spending habits. In addition, programs that allow older students to teach tobacco-use prevention to younger ones are popular with both sets of students and have been shown to be effective in some settings.[2]

Educational Guidelines from CDC

Successful programs to prevent tobacco use address multiple psycho-social factors related to tobacco use among children and adolescents. These factors include:

- IMMEDIATE AND LONG-TERM UNDESIRABLE PHYSIOLOGIC, COSMETIC, AND SOCIAL CONSEQUENCES OF TOBACCO USE. **Programs should help students understand that tobacco use can result in decreased stamina, stained teeth, foul-smelling breath and clothes, exacerbation of asthma, and ostracism by nonsmoking peers.**
- SOCIAL NORMS REGARDING TOBACCO USE. **Programs should use a variety of educational techniques to decrease the social acceptability of tobacco use, highlight existing anti-tobacco norms, and help students understand that most adolescents do not smoke.**
- REASONS THAT ADOLESCENTS SAY THEY SMOKE. **Programs should help students understand that some adolescents smoke because they believe it will help them be accepted by peers, appear mature, or cope with stress. Programs should help students develop other more positive means to attain such goals.**
- SOCIAL INFLUENCES THAT PROMOTE TOBACCO USE. **Programs should help students develop skills in recognizing and refuting tobacco-promotion messages from the media, adults, and peers.**
- BEHAVIORAL SKILLS FOR RESISTING SOCIAL INFLUENCES THAT PROMOTE TOBACCO USE. **Programs should help students develop refusal skills through direct instruction, modeling, rehearsal, and reinforcement and should coach them to help others develop these skills.**
- GENERAL PERSONAL AND SOCIAL SKILLS. **Programs should help students develop necessary assertiveness, communication, goal-setting, and problem-solving skills that may enable them to avoid both tobacco use and other health-risk behaviors.**

—Centers for Disease Control and Prevention[3]

Collaboration among schools, families, and communities

The potent role of contextual environmental factors in young people's use of tobacco argues for involvement of the entire community in educational efforts. Ensuring the involvement of public health professionals and others in the community is critically important. School-based activities should be well coordinated with community-wide tobacco-use prevention programs to enhance the effectiveness of both (see box, "Integrated Community-Wide Campaigns").

Integrated Community-Wide Campaigns

Community-wide anti-tobacco campaigns can promote anti-tobacco attitudes and behaviors among adolescents and their parents and can significantly reduce the rate of tobacco use by adolescents, especially if multiple prevention components are used. Indeed, research demonstrates that multi-component community interventions are more effective than single interventions. On the practice side, it is recommended that practitioners utilize multi-component interventions that involve the community and its organizations and agencies, its schools, and the media. Moreover, the elements of a multi-component intervention should be integrated and should support and enhance each other.

—U.S. Center for Substance Abuse Prevention[26]

The experience of the California Tobacco Control Program suggests that students' attitudes are most influenced when school-based education is combined with media campaigns and other community-based interventions.[27] Mass media interventions have been shown to enhance the effectiveness of school-based programs to prevent tobacco use in other states as well.[28]

Students can be encouraged to become involved in community activities to prevent tobacco use in a number of ways, such as signing petitions, protesting tobacco industry support for sports or entertainment events, sending letters to newspapers, or participating in supervised "stings" of merchants who are willing sell tobacco products to underage youth.

To the extent possible, educational campaigns should be based on local public health data and needs assessments conducted with community input. Educational objectives and prevention strategies ought to be tailored to the specific needs and issues of the populations being addressed. For example, American Indian and Alaska Native adolescents have higher rates of cigarette smoking than all other ethnic categories for whom data are available; rates of using spit tobacco are also high among these groups.[29] Chart 3, "Who Is Smoking?" on the following page demonstrates how smoking rates vary by race and ethnicity and how these rates are changing over time.

Parents are important role models for children and a powerful influence on whether their children take up smoking.[4,30] Family involvement should be designed into every aspect of the prevention education program.

Teacher preparation

Effective teaching of tobacco-use prevention, and health education in general, requires a body of knowledge and instructional skills: that are uniquely different from the skills necessary to teach other subject areas. This is because health classes aim to influence students' personal *behaviors* and not just to build their knowledge base and develop their cognitive skills. For example, examining the subtle influences of peer modeling is a critical aspect of prevention education that many other teachers typically might not address.

According to CDC only 11 percent of health education classroom teachers had participated in training for tobacco-use prevention education in the two years before a 1994 survey.[13] Perhaps in part because of this lack of training, only 59 percent reported teaching tobacco-use prevention.[14]

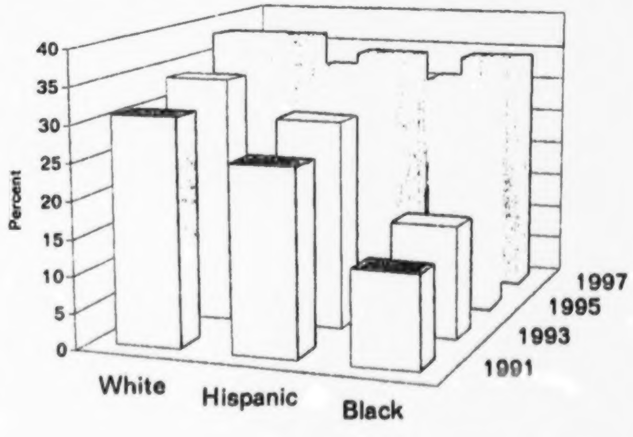
Teachers need adequate preparation to teach prevention skills, with ongoing support and continuous professional development. CDC has found that, "Adequate curriculum implementation and overall program effectiveness are enhanced when teachers are well prepared to deliver the program as planned. Studies indicate that in-person training and review of curriculum-specific activities contribute to greater compliance with prescribed program components."[2]

Go to pages C-41–49 in the "General School Health Policies," chapter for a more detailed discussion about teacher preparation and professional development.

Chart 3

Who Is Smoking?

Percentage of High School Students Who Smoked Cigarettes on One or More of the Thirty Days before the Survey, by Race/Ethnicity, 1991–97



—Centers for Disease Control and Prevention[4]

Resources

- Your state or district education agency might have required or recommended curriculum frameworks and/or materials available for use.

- The Research to Classroom project of CDC's **Division of Adolescent and School Health** (DASH) has identified two curriculum programs that have demonstrated clear evidence of reducing tobacco use among adolescents:

  - Life Skills Training (LST) is available from **Princeton Health Press** at (609) 921-0540; and

  - Project Towards No Tobacco Use (Project TNT) is available from the **University of Southern California** at (213) 342-2586.

  For more information about the Research to Classroom project, call (770) 488-3168 or go to www.cdc.gov/nccdphp/dash.

- CDC's **Office on Smoking and Health** offers a number of resources including the following:

  - "MediaSharp" is a video with an accompanying teacher's guide for middle and high school students that is designed to help them understand and analyze tobacco and alcohol messages in the media. Call (770) 488-5705 and press 2 for publications or send an e-mail message to tobaccoinfo@cdc.gov.

  - "Smoke Screeners" is a media literacy program aimed at increasing middle and high school students' awareness of tobacco use in the movies. It was created by the **Massachusetts Department of Health** and adapted by the CDC. Call (800) CDC-1311 or go to www.cdc.gov/tobacco.

- Kids Act to Control Tobacco (Kids ACT!) is a middle school curriculum that teaches students tobacco control advocacy skills. For information call the **National Education Association Health Information Network** at (800) 718-8387 or e-mail at NEAHIN1@aol.com (available Summer 2000).

- The **American Cancer Society** has a variety of curricula and materials for tobacco-use prevention. Call (800) ACS-2345 or go to www.cancer.org.

- The **American Heart Association** also offers a number of education materials to prevent tobacco use. Call (800) AHA-USA1 or go to www.americanheart.org.

- The **March of Dimes Birth Defects Foundation** distributes health education materials about the effects of smoking during pregnancy. Contact (914) 428-7100 or www.modimes.org.

- **Doctors Ought to Care** (DOC) provides school curricula, smoking intervention information, and tobacco counter-advertisements for use in clinics, classrooms, and communities. Contact (713) 528-1487 or go to www.bcm.tmc.edu/doc.

- N-STEP, the National Spit Tobacco Education Program of **Oral Health America**, assists with the development of state and community coalitions involving Major League Baseball and organized dentistry. For information and materials call (312) 836-9900.

- The **American Nonsmokers' Rights Foundation** publishes an advocacy guide for young people. Contact (510) 841-3032.

- The **Campaign for Tobacco-Free Kids** is a public policy advocacy organization that sponsors the annual Kick Butts Day, a nationwide event that encourages leadership and activism among kids, and the Youth Advocate of the Year Awards to recognize and celebrate outstanding young tobacco control activists who are making a difference in their communities. Contact (800) 284-KIDS or www.tobaccofreekids.org.

4. Assistance to Overcome Tobacco Addiction

It is not enough for school leaders to focus on enforcing punitive sanctions with students who use tobacco. School policymakers should support organized programs to help students and staff who want to overcome tobacco addiction.

Sample Tobacco-Use Prevention Policy, Part Four:

PROGRAM AVAILABILITY. The school health program shall include referrals to community resources and programs to help students and staff overcome tobacco addiction. School counselors or community agencies are encouraged to establish voluntary tobacco-use cessation programs at school.

PROGRAM ATTENDANCE. Attendance or completion of a tobacco-use cessation program shall not be mandatory for anyone or used as a penalty. Attendance or completion of a tobacco-use cessation program is allowed as a voluntary substitute to suspension for possession or use of tobacco.

Discussion

Tobacco-use cessation programs for students and staff who are physically addicted to tobacco are an important component of a comprehensive policy that addresses tobacco use. Provision of cessation programs supports the tobacco-free environment and instructional program by:

- giving current smokers the chance to quit;
- providing a positive alternative to punishment; and
- demonstrating that policymakers are concerned about the health of students and staff.

Many children who smoke quickly become addicted, just like adults. Eighty-four percent of 12 to 17-year-olds who smoke one or more packs of cigarettes per day say they are "dependent" on smoking.[5] Most

Trying to Quit

Among 12–18-year-old smokers, in 1989:

- **74 percent had seriously thought about quitting;**
- **64 percent had tried to quit; and**
- **49 percent had tried to quit during the previous six months.**

—CDC Office on Smoking and Health[22]

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adolescent smokers report that they would like to quit smoking and that they have made numerous, usually unsuccessful, attempts to quit.[5] They experience relapse rates and withdrawal symptoms similar to those reported by adults.[22]

Yet policymakers need to be realistic about the limited effectiveness of tobacco cessation programs. According to the Surgeon General, adolescents are difficult to recruit for these programs and, when enrolled, are difficult to retain.[5] Success rates in adolescent cessation programs tend to be quite low.[5]

This is not surprising. Most (93 percent) adult smokers who try to quit resume smoking on a regular basis within one year. Of those persons who successfully quit smoking for one year or longer, one-third eventually relapse.[2] The average adult smoker tries to quit smoking seven times before succeeding. Most people who successfully quit smoking do so without the help of formal programs, therapy, or nicotine-replacement devices.[5]

Program design

Although little research evidence exists that defines what types of programs may successfully help young people to quit using tobacco, schools can and must support students' efforts to quit. It is important to remember that young people may require numerous attempts before they are finally able to break the addiction of tobacco use.

Schools can organize tobacco cessation programs by using a variety of strategies that vary in length and intensity.[31] Activities might include some combination of:

- self-help printed materials;
- brief interventions by health care providers;
- one-session educational classes, typically two to three hours long;
- multi-session classes conducted during the school day or within the community during evenings and on weekends, typically six to eight sessions;
- group support;
- nicotine replacement therapy;
- social support;
- skills training and problem solving; and
- referral to inpatient treatment.

Some schools have integrated tobacco education and cessation classes for tobacco violators into the school day. Students attend during a study period, lunch hour, or during regular classes by rotating the class period to minimize disruption for any one class.[31]

Community programs

Schools can also refer students to community-based programs and establish other links with agencies in the community. For example, since 1977 the American Cancer Society has sponsored the annual "Great American Smokeout" to promote community-based activities designed to encourage smokers to refrain from smoking cigarettes for at least 24 hours. In 1997, nearly 11.3 million smokers (approximately 24 percent of all smokers) reported participating in the Smokeout, and 19 percent of participants reported smoking less or not at all one to five days after the Smokeout.[32]

Resources

- Resources to help young people quit using tobacco are available online at www.quitsmokingsupport.com and www.quitnet.org.
- The **American Cancer Society** (ACS) distributes pamphlets, posters, and exhibits on smoking and provides smoking education, prevention, and cessation programs. ACS offers the *Commit to Quit* program for adult smokers and a *Resource Guide to Youth Tobacco Cessation Programs*. Refer to your phone book for the ACS chapter in your area, contact (800) ACS-2345, or go to www.cancer.org.
- The **American Lung Association** (ALA) conducts programs that address smoking cessation, prevention, and protection of nonsmokers' health and provides a variety of educational materials. Refer to your phone book for the ALA chapter in your area, contact (800) LUNG-USA, or go to www.lungusa.org.
- The **American Heart Association** (AHA) promotes smoking intervention programs at schools, workplaces, and health care sites. Refer to your phone book for the AHA chapter in your area, contact (800) AHA-USA1, or go to www.americanheart.org.
- Smoking cessation resources are available from the federal **Agency for Health Care Policy and Research** (AHCPR). Call (800) 358-9295 or go to www.ahcpr.gov.
- The CDC **Office on Smoking and Health** offers the booklet *I Quit!* and other resources on tobacco cessation. Call (770) 488-5705 or go to www.cdc.gov/nccdphp/osh.

References

[1] Quoted in: Minneapolis Heart Institute Foundation, *Smoking Cessation Resource Directory*, October 1996.

[2] Centers for Disease Control and Prevention, "Guidelines for school health programs to prevent tobacco use and addiction," *MMWR*, February 25, 1994, Vol. 43, No. RR-2.

[3] McGinnis, J.M. and Foege, W.H., "Actual causes of death in the United States," *Journal of the American Medical Association*, 1993; 270(18): 2207–2212.

[4] CDC Office on Smoking and Health, "Overview," at www.cdc.gov/nccdphp/osh/issue.htm, based on National Center for Health Statistics, *Advance Report of Final Mortality Statistics*, 1996.

[5] Office on Smoking and Health, *Preventing Tobacco Use Among Young People: A Report of the Surgeon General*, U.S. Department of Health and Human Services, 1994.

[6] Centers for Disease Control and Prevention, "Youth risk behavior surveillance— United States, 1997," *MMWR*. August 14, 1998, Vol. 47, No. SS-3.

[7] Centers for Disease Control and Prevention, "Cigar smoking among teenagers— United States, Massachusetts, and New York, 1996," *MMWR*, May 23, 1997, Vol. 46, No. 20.

[8] Everett, S. et al., "Other substance use among high school students who use tobacco," *Journal of Adolescent Health*, 1998; 23: 289–296.

[9] Shalala, D., Secretary, U.S. Department of Health and Human Services, Testimony before the Senate Labor and Human Resources Committee, September 25, 1997.

[10] Gross, J., "Youths tie tobacco use to marijuana," *New York Times*, April 22, 1998.

[11] CDC Office on Smoking and Health, *Making Your Workplace Smokefree— A Decision Maker's Guide*, 1996. Available at www.cdc.gov/nccdphp/osh.

[12] Glantz, P.A. and Parmley, W.W., "Passive smoking and heart disease: Epidemiology, physiology, and biochemistry," *Circulation*, 1991; 83(1): 1-12.

[13] Ross, J. et al., "School health policies prohibiting tobacco use, alcohol and other drug use, and violence," *Journal of School Health*, 1995; 65(8): 333–338.

[14] Portner, J., "Despite heat on tobacco producers, some schools still permit smoking," *Education Week*, Vol. XVII, No. 9, October 29, 1997.

[15] Colorado ASSIST, *Getting to Tobacco-Free Schools: A Trouble Shooting Guide*.

[16] Sargent, J. et al., "Cigarette promotional items in public schools," *Archives of Pediatrics and Adolescent Medicine*, 1997; 151(12): 1189–96.

[17] Pennsylvania School Boards Association, "Act 145 of 1996: School tobacco control," *Policy Network News*, January 1997.

[18] Wolk, D., Chair, Vermont State Board of Education, in a September 1, 1997 memo to local school board chairs.

[19] Acott, C. et al., *Creating Tobacco-Free Schools*, as quoted in the 1996 Tobacco-Free Schools Resource Packet of the University of Colorado Health Sciences Center.

[20] Prevention Enhancement Protocols System, *Reducing Tobacco Use Among Youth: Community-Based Approaches*, Center for Substance Abuse Prevention, U.S. Department of Health and Human Services, 1997, Publication Number (SMA) 97-3146.

[21] Hacienda La Puente Unified School District, California policy dated January 19, 1995.

[22] CDC Office on Smoking and Health, "Youth and nicotine addiction: Background," undated. Available at www.cdc.gov/nccdphp/osh.

[23] National Institutes of Health, *Smokeless Tobacco or Health: An International Perspective*, NIH pub. 93-3461.

[24] Institute of Medicine, *Growing Up Tobacco Free: Preventing Nicotine Addiction in Children and Youths*, 1994, Washington, DC: National Academy Press.

[25] Elementary and Secondary Education Act; Title V— Safe and Drug-Free Schools and Communities; Section 4002— Findings.

[26] CDC Office on Smoking and Health, "Coaches— You can influence youth," fact sheet available at www.cdc.gov/nccdphp/osh/Yuthfax3.htm.

[27] California Department of Health Services, *Final Report of the Independent Evaluation of the California Tobacco Control Prevention and Education Program: Wave 1 Data, 1996–97*, Tobacco Education Clearinghouse of California.

[28] Flynn, B. et al., "Prevention of cigarette smoking through mass media intervention and school programs," *American Journal of Public Health*, 1992; 82(6): 827–834.

[29] U.S. Department of Health and Human Services, *Tobacco Use Among U.S. Racial/Ethnic Groups Minority Groups: A Report of the Surgeon General*, 1998, p. 49.

[30] Conover, K., "Keeping kids from lighting up," *Christian Science Monitor*, July 29, 1998.

[31] Minnesota Institute of Public Health, *Tobacco-Free School Policies: Best Practices*, 1998, p. 23.

[32] Centers for Disease Control and Prevention, "The Great American Smokeout," *MMWR*, November 6, 1998.

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